Impacts of Congregation-based HIV/AIDS Programmes In Lusaka, Zambia: How Abstinence and Marital Fidelity Efforts Function In Overall Strategies Addressing HIV/AIDS

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Abstract

The 2013-2014 Zambia Demographic and Health Survey (ZDHS) reported HIV prevalence rate among adults aged 15-49 at 13.3%, ranking Zambia 7th among countries experiencing devastating effects of a mature and generalised epidemic. This report is particularly noted as the first to measure HIV incidence[1]. Chanda Kapata[2] *et al*. posting results from Zambia's largest population-based mobile testing survey (2013–2014) placed the HIV prevalence rate generally lower. In 2002, the National AIDS Council (NAC) was established to lead a multi-sectoral national response to stem the tide. Government Agencies and the United Nations led the responses. In 1992, The World Health Organisation (WHO) observed that abstinence and marital fidelity might constitute strategies capable of completely eliminating the risk of infection from HIV and other sexually transmitted diseases (STDs). Yet funding for applicable initiatives has seldom been prioritised in this respect. On one hand, from the onset of global interventions, condoms were seen primarily as most potent towards reducing the risk of infection. On the other hand, in due course, the implementation of Abstinence and Being Faithful (AB) initiatives by Churches among others, has since been seen as holding massive comparative advantage in facilitating sustainable interventions for prevention and mitigation of AIDS impact. However, church-congregation engagement in AIDS work, for a while, remained under-researched, and applicable interventions were often undocumented and unmeasured in relation to impact. This study investigated (1) how interventions affect impacts in congregation-based HIV/AIDS programmes, and (2) how abstinence and marital fidelity function within the larger picture of overall strategies to combat AIDS. It examined the community work of the Circle of Hope Family Care Centre, a congregation-based HIV/AIDS support group initiative undertaken by the Northmead Assembly of God Church

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[1] Central Statistical Office (CSO) Zambia, Ministry of Health (MOH) Zambia and ICF International. Zambia Demographic Health Survey 2013/2014. Rockville, Maryland, USA: Central Statistical Office, Ministry of Heath, and ICF International. 2014.

[2] Chanda-Kapata, P., Kapata, N., Klinkenberg, E., William, N., Mazyanga, L., Musukwa, K., … Mwaba, P. (2016). The adult prevalence of HIV in Zambia: results from a population based mobile testing survey conducted in 2013–2014. *AIDS Research and Therapy*, *13*, 4. http://doi.org/10.1186/s12981-015-0088-1

in Lusaka, Zambia. The main research question was: 1) Is a person's sexual behaviour influenced by their attitude and behaviour towards God? Two subsidiary questions were: i) what are the factors that affect a person's sexual lifestyle? ii) Does attendance at the church's HIV/AIDS programmes cause a change of behaviour in a person's sexual relationships? A triangulated methodology required the collection of both quantitative and qualitative data. The experimental design included a purposively selected intervention group and a control group. Both groups were studied by employing baseline first, and follow-up measures after three months. Quantitative data analysis was carried out in two stages comprising first, *cross tabulations* to examine the relationship between safer sexual behaviour and socio-economic variables. For the statistical analysis, *chi-square* tests of independence were conducted at the bivariate level, and the differences were determined at $P < 0.01$ and $P < 0.05$ significant level. Next, major predictors were carried out with the help of logistic regression analysis. The results of the logistic regression models were converted into odds ratios, which represented the effect of a one-unit change in the explanatory variable on the indicator of experiencing safer sexual practices and abstaining from sex. Qualitative data were analysed using *Atals.ti* software to produce the attendant themes and sub-themes. The results of the logistic regression analysis show that those who participated in the interventions were *4.1 times* more likely to report having adopted new behaviour or modified old behaviour, specifically to live positively, than those who did not attend the interventions. Similarly, participants in the faith-based interventions were *2.3 times* more likely than those who did not take part to report having adopted safer sexual practices. Further analysis revealed that those participants were more likely to report abstinence from sex than those who did not attend. The conclusion is that church congregations have immense comparative advantage to influence sexual behaviour through increasing captive audiences constituting the churches' presence in the community. Additionally, their morally based interventions such as abstinence and marital fidelity show significant impact on sexual behaviour change and have potential to turn the tide of HIV/AIDS, as the tested models are replicable, scalable and sustainable.

Impacts of Congregation-based HIV/AIDS Programmes In Lusaka, Zambia:

How Abstinence and Marital Fidelity Efforts Function In Overall Strategies Addressing HIV/AIDS

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DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed Joshua HK Banda (Candidate)

Date 08 September, 2016

STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated. Where correction services have been used, the extent and nature of the correction is clearly marked in a footnote.

Other sources are acknowledged by midnotes or footnotes giving explicit references. A bibliography is appended.

Signed Joshua HK Banda (Candidate)

Date 08 September, 2017

STATEMENT 2

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Date 08 September, 2017

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ABBREVIATIONS/ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ABY	Abstinence, Be faithful Youth
ARV/ART	Anti-Retroviral /Anti-Retroviral Therapy
CAF	Children's AIDS Fund
CBO	Community Based Organisation
CCC	Crossroads Christian Communications
CCZ	Council of Churches of Zambia
CCM	Country Coordinating Mechanism
CDC	United States Centers for Disease Control and Prevention
CD_4	Cluster of Differentiation$_4$
CHAZ	Churches Health Association of Zambia
CIDA	Canadian International Development Agency
COH	Circle of Hope
CBTS	Community-Based Treatment Support
CRS	Catholic Relief Services
CSO	Central Statistical Office
DATF	District AIDS Task Force
ECR	Expanded Church Response to HIV/AIDS Trust
EFZ	Evangelical Fellowship of Zambia
FBO	Faith Based Organisation
FHI	Family Health International
GBV	Gender Based Violence
GBVSS	Gender Based Violence Survivor Support

GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)
HPCZ	Health Professionals Council of Zambia
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IMPACT	Implementing AIDS Prevention And Care
LCMS	Living Conditions Monitoring Survey
LGBT	Lesbian, Gay, Bisexual and Transgender
LTS	Life Transformation Seminar
M&E	Monitoring and Evaluation
MARPS	Most at Risk Populations
NAC	National HIV/AIDS/STI/TB Council
NASF	National AIDS Strategic Framework
NCC	National Constitutional Conference
R-NASF	Revised National AIDS Strategic Framework
NGO	Non-Governmental Organisation
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PAOGZ	Pentecostal Assemblies of God (Zambia)
PEPFAR	President's Emergency Plan for AIDS Relief
PLWH	People Living With HIV
PRSP	Poverty Reduction Strategy Paper
RAPIDS	Reaching HIV/AIDS Affected People with Integrated Development and Support

SDA	Seventh Day Adventist
SHARPZ	Serenity Harm Reduction Programme in Zambia
UNAIDS	United Nations AIDS Programme
UNGASS	United Nations General Assembly
USG	United States Government
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
VMMC	Voluntary Medical Male Circumcision
WB	World Bank
WHO	World Health Organisation
WVZ	World Vision Zambia
ZAMFAM	Zambia Family
ZMA	Zambia Medical Association
ZDHS	Zambia Demographic and Health Survey
ZEC	Zambia Episcopal Conference
ZHDR	Zambia Human Development Report
ZINGO	Zambia Interfaith Network Organisations
ZNBTS	Zambia National Blood Transfusion Service
ZOCS	Zambia Open Community Schools

INTRODUCTION

Thesis Overview, Research Focus and Problem Addressed

This Thesis focuses on (1) how interventions affect impacts in congregation-based HIV/AIDS programmes, and (2) how abstinence and marital fidelity function within the larger picture of overall strategies to combat AIDS. It was achieved by examining the community outreach work of the Circle of Hope Family Care Centre, a congregation-based HIV/AIDS support group initiative undertaken by the Northmead Assembly of God Church in Lusaka, Zambia.

The research sought to make a new contribution to the body of knowledge by learning how interventions affect impacts and how abstinence and marital fidelity function in the whole range of strategies to turn the tide of AIDS. The study designed a main faith-based intervention built around Life Transformation Seminars (LTS) that lasted for a duration of three months (modules in 3 parts +1 open discussion in between each) – See chapter 3). The LTS were comprised of bible content only without a specific mention of HIV. However, HIV was discussed directly through Focus Group Discussions (FGDs) and through other survey tools designed for the Study.

The study was built around one main research question which was: 1) Is a person's sexual behaviour influenced by their attitude and behaviour towards God? Two subsidiary questions were: i) what are the factors which affect a person's sexual lifestyle? ii) Does attendance at the church's HIV/AIDS programmes cause a change of behaviour in a person's sexual relationships?

A triangulated methodology required the collection of both quantitative and qualitative data. The experimental design included a purposively selected

intervention group and a control group. Both groups were studied by employing baseline first, and follow-up measures after three months. The study then developed a working hypothesis that "***a person's sexual behaviour is influenced by their attitude and behaviour towards God. Further, in the context of this study, the intervention [here designed] does make a difference to the sexual behaviour of those undergoing it".***

The logistic regression analysis results of the study agreed with the research hypothesis and therefore proved that the main intervention was significantly effective in changing sexual behaviour.

The study hereby makes a makes a contribution to the body of knowledge by opening a fresh window into the potential of low cost interventions in church congregation settings and the potential of adding fresh energies towards the implementation of behavioural change HIV programmes.

It is noted that while the research process begun with a proposal submitted at the end of 2007, when the researcher commenced the journey as a part-time research student, the thesis is being completed in June 2015, shortly after the release of the latest population-based (Demographic and Health) survey for Zambia (2013-14). It is particularly important to note that newest results around Zambia are showing the robustness of a national response which has tracked several national programmes following the 2005 national HIV policy and three successive National Strategic Frameworks.

During that period, the researcher was Chairperson of the National AIDS Council and so assisted the Circle of Hope to play its role in the community by following the national policy for its programmatic planning. The further decline in national HIV prevalence from 14.3 % to 13.3 % is observed to be a result of the

robust national policy and multi-sectoral response implementing a range of interventions including AB related ones. The potential of grassroots level behavioural programmes such as what has worked at COH is worth noting, being that the value and importance of such initiatives are well confirmed, in kind, by the nation-wide survey in current reference.

The study has drawn applicable conclusions, observed some limitations and proposed recommendations for future research in the concluding chapter.

CHAPTER 1: PROLEGOMENA- BACKGROUND, CONTEXT AND PRE-CURSORS TO THE STUDY

1.1 Genesis of Personal Involvement In HIV: Family And Church Funerals

If a chronicle of the various pre-cursory experiences was to be compiled, the story begins in 1990 with the extended poor health that beset Idah, my sister in marriage. Nearly all in the family knew her illness to be HIV-related but none were courageous enough to talk about it openly. Then the inevitable happened: Idah became bed-ridden and eventually died in the last quarter of that year. A 5-year-old son, Zemba and a husband, Charles, survived her. This was the beginning of a series of precursors to the study quest. A number of 'attention-getters' emerged.

Within a year, Charles fell very ill, exhibiting symptoms similar to Idah's. This time, a few family members quietly discussed long-term alternative treatment and care options, in view of a rapidly deteriorated health condition that faced Charles despite being on an ART regime administered to him during extended hospitalization. In due course, in the first quarter of 1992, Charles was recommended for home care and discharged from hospital but died three days later at his home.

Notwithstanding the sorrow that befell the family, some rare details surrounding Charles' death are worth noting. Those that had been by the bedside just before he died reported that Charles suddenly begun to speak (after having mysteriously lost his voice the previous day). He requested the family members to sing two hymns, known historically as fondly held by many in the Christian church-

"It's not and easy road" and *"It is well with my soul."* Soon after that Charles is reported to have broken spontaneously into a language the persons present could not understand. He is said to have appeared engaged deeply in some intense form of prayer and that he looked really happy. Following that instance, Charles is said to have waved to the family, specifically verbalizing the word- "bye"- before he died. In retrospect, family members who knew about Charles' prior experience of salvation in Jesus Christ described those last moments as characterised by an enduring expression of peace, hope and faith in the face of pain. Personally, I linked one aspect of this rare event to the hymn writer of one of the songs Charles selected. Following the loss of his four children in a tragic sea accident in 1873, HG Spafford wrote, *"no pangs shall be mine for in death as in life, thou shalt whisper thy peace to my soul."*

One could also be right to associate the occurrence of Charles' speaking of an unknown language with the biblical phenomenon of *glossolalia*[1] - spontaneous breaking into an unknown language or tongue, cases of which are recorded severally in the New Testament book of Acts of Apostles particularly in passages such as Acts chapters 2:1-4; 10:44, among others. In the applicable contexts, "tongues" are considered to be supernaturally associated with the experience of the baptism in the Holy Spirit and/or instances of spontaneous religious worship. The phenomenon is particularly prominent in the Apostle Paul's first letter to the Corinthian believers (chapters 12-14) where he provided related guidelines for propriety in worship.

[1] Richard Hogue in *Tongues: A Theological History of Christian Glossolalia* provides biblical evidence, chronologically tracing relevant occurrences of the phenomenon through out Christian history. One review of the book states: "From Saul of Tarsus to John Wesley, from Pentecost to Azusa Street, Richard Hogue follows the gift of tongues and clearly draws a picture of today's role of the Holy Spirit.

Pentecostal and Charismatic Christians largely espouse these and other faith related practices.

After the loss of Charles, more happened. In 1995, my youngest sister Jenny was taken deathly ill. Her husband reported that she had been placed on ART but it appears this act may have been a case of 'too little too late'. About mid-year, Jenny was taken into our older sister's home for home-based care. Shortly thereafter, she died. The passing of three close family members within a relatively short space of time was a commanding attention-getter. HIV was no longer a 'tale' out there. It had been 'felt' and 'touched' by all within my family.

Another attention-getter was the apparent increasing number of funerals affecting church members. One particular week we registered five funeral services. It was fairly obvious at this time that the majority of these deaths were AIDS-related. Therefore, the questions that lingered from hereon pointed beyond mitigating the devastating effects of the disease, to the issue of what could be done to prevent the spread of HIV infections that were fuelling AIDS to such devastating extents?

My own family had already suffered the massive negative impact of the epidemic. What role could I play personally to help stem the tide? This was the beginning of eight years of listening and learning from parishioners in our congregation, which resulted in the birth of the Circle of Hope initiative along with two other social outreach/AIDS initiatives namely, the *Lazarus Project*[2] and *Operation Paseli*[3].

[2] A social outreach arm of Northmead Assembly initially targeting the rescue and rehabilitation of street children (infected and/or affected by HIV) who were later re-integrated into society. Currently expanded to provide holistic care generally to orphaned and vulnerable children, their families and communities.

[3] A social arm of Northmead Assembly of God targeting outreach to and rehabilitation of commercial sex workers

As this research is woven around the Circle of Hope Initiative, key highlights regarding the COH are provided in Section 8. In the meantime, the following antecedents need to be mentioned in the personal journey that culminated in the current research. The attendant social dynamics that appeared to shape the matrix of HIV progression in my local context were highly instructive, particularly in the years between 1999 and 2003. We turn to the second precursor to the research.

1.2 The 6AM Call Leading to the Formation of Operation Paseli: An Outreach to, And The Rehabilitation of, Commercial Sex Workers

One Saturday morning, I was awakened at 6am by what turned out to be an extraordinary call from the Youth Director of our Church. The youths had been in a prayer vigil all night, which had ended at 05:30 hrs. The caller reported that they had just seen two adults (a man and a women) having sex on the pavement by the roadside, barely 10 metres from the main gate of the Church. He further narrated that the scene in question was so perplexing that he and others were not sure what to do. Hence the urgent call. They reported having concluded that the lady involved was most probably a prostitute, as many young prostitutes often paraded on the street near Church.

I encouraged the young leader to take heart, adding that what he and others had just witnessed was, in reality, a manifestation of deep social and spiritual needs of our community – and just as well they (youths) had come from a prayer meeting. They could now intensify prayer vigils even more. The seriousness of the reported incident was significant. Thus, in typical Pentecostal tradition, I resorted to God for

divine guidance and courage eventually to address the congregation for communal action.

It is worth noting that Pentecostalism[4] has, since its inception in the early 1900s, emphasised the importance of personal as well as corporate prayer, particularly in times of difficulty. Some biblical precedents undergirding this norm among Pentecostals include New Testament passages such as Acts 4:23-31 where the narrative bears record of imminent threats and difficulties faced by the then Apostles at the hands of the State authorities. This biblical reference reports that the Apostles "*… raised their voices together in prayer to God…*"[5] and that "*after they had prayed, the place where they were meeting was shake. And they were all filled with Holy Spirit and spoke the Word of God boldly*."[6]

A number of troubling questions lingered in my mind, as I turned to prayer the remainder of that day: *What was the real state of our witness as a Church in this location? What difference, if any, were we making in the community, so far? How could we reconcile our Mission with the rampancy of prostitution and other risky*

[4] Pentecostalism as a movement; has a characteristic doctrinal teaching concerning "baptism with the Spirit" (or "Spirit baptism" for short) which is unique from any other past movement in history. "It bears strong commonalities with evangelical doctrines while testifying to long-neglected truths about the work of the Holy Spirit..." It began with a belief that in its origin God was restoring New Testament Christianity to the church today by bringing a discovery and recovery of certain truths and experiences of the Spirit. And now by virtue of its rapid growth and huge worldwide influence, Pentecostalism today is increasingly bringing such a 'restoration' to the church because of the way it is "reshaping Christianity in the twenty-first century." Pentecostalism… characteristically emphasises the working and gifts of the Spirit… with a special focus on baptism with the Spirit, the gift of tongues and the other spiritual gifts of 1 Corinthians 12:8-10. What makes Pentecostalism unique from other charismatic movements is its distinctive doctrine of Spirit baptism, and the priority [it gives to prayer] and to the gifts of the Spirit, particularly the gift of tongues. This comes from a particular reading of the Pentecost events: Acts 2 when baptism with the Spirit was first given to Jews, and Acts 8, 10 and 19 when it was repeated among Samaritans, Gentiles and some of John's disciples. Pentecostalism teaches that baptism with the Spirit is a post-conversion experience of empowerment for supernatural Christian living, with "speaking in tongues"6 as the initial physical evidence. Extract from *Talking Pentecostalism- Pentecostal belief, the Holy Spirit and Evangelicalism.* (http://talkingpentecostalism.blogspot.kr/2006/10/what-is-pentecostalism.html) Accessed 7th May 2015.

[5] Acts 4:24

[6] Acts 4:31

behaviours that had now become characteristic of the night incidents in the vicinity of the Church?

The next day, during the main Sunday Service, I announced my conclusions to the congregation: First, I narrated the 6am call and the subsequent deep spiritual reflections gleaned through prayer. Second, that in the wake of this development, we would suspend our usual weekly Evening Services and instead go on the streets (in pairs or triplets), to talk to the commercial sex workers. I lamented that there was no way we could carry on with worship and prayer in the 'four walls' of the Church while the community around us faced unprecedented social challenges. I was encouraged that as I made these bold declarations, there was high enthusiasm and positive acclamation with loud shouts of *"Amen! Amen!"* from the congregation. I emphasised that we were not going out to condemn the target group in reference, but rather we were setting out to understand why they were given to this lifestyle, knowing the dangers of HIV/AIDS and other sexually transmitted infections. We were going out there to learn and help to create a response to the needs we would discover in due course.

From the street outreach activities that followed, we learnt a lot:

- Due to a combined impact of AIDS related deaths of key family providers/heads, and the destabilisation of households caused by escalating poverty levels, many young girls ended up attempting to earn money by marketing their bodies for sex.
- As such they have become an extremely high-risk group in regard to the dangers posed by growing HIV/AIDS infections.

- This finding is confirmed by a study undertaken by Kalinda and Tembo (2010) in Mansa district of the Luapula province of Zambia, which revealed that:

> the rise in poverty levels has led to an increase in transactional sex and marital infidelity among unemployed youth and vulnerable women. Since people's efforts to change risky sexual behavio[u]r [are] often thwarted by factors such as poverty and gender inequalities.

It was most shocking to discover that some ladies interviewed during the nightly outreach visits were reportedly married and were on the streets with the full 'consent' of their respective husbands, as this was their chosen way of ensuring livelihood at home. However, the ladies in question also complained that. at times, they did not 'benefit' from the money earned, as it would be surrendered to their respective husbands who in this case were in the habit of squandering the money on alcohol.

It was also shocking to discover that some of the girls on the streets were as young as 13 years of age. The oldest met were in the mid-30's range. Some of the girls reported that their street 'earnings' were being done on behalf of entire families. Asked whether they would be willing to consider other means of survival, all the girls interviewed responded in the affirmative, indicating readiness to take any such alternative, as they were aware of the apparent predisposition to the risk of HIV infection if they continued in prostitution. We seized this window of opportunity swiftly as it set the stage for the intervention we eventually called *"Operation Paseli." (Paseli* is the name of the street along which our church is located, which was/is frequented by numerous commercial sex workers).

Following many weeks of interaction with the target group, some girls were enrolled into a Skills Training course that had been designed earlier for other vulnerable women at the Church. The first few were offered temporary shelter to

facilitate easier access to counselling services. An integrated group of 30 widows, including 25 rehabilitated former sex workers, completed the first phase and were granted micro –credit loans and sewing machines to assist them towards income generation. Some testified that, for the first time in their lives, they were now involved in honest and gainful activity.

The programme progressed into a second phase of Skills Training with another enrolment of 50 commercial sex workers who underwent gradual rehabilitation. Those enrolled soon began to show strong commitment to a changed lifestyle and became very consistent in attending training sessions, held twice a week. A third of those in training were actually recruited by word of mouth through their peers who every once in while asked the trainers if they could bring their friends from the streets to the sessions.

The courses taught included:

- Life skills and values of chastity, fidelity and fulfilled living
- Personal Hygiene
- Basic Home Economics and Nutrition
- Basic Tailoring and Design
- Making Tie and Dye materials
- How to start a small business
- Budgeting and managing of finances
- HIV/AIDS and the dangers of high risk sexual life styles

The courses, which were covered over a 6-month duration, also included individual psychosocial counselling, as well as interactive activities to enhance interpersonal skills. Exposure visits to hospitals and hospices became an important

way for initiating discussions on HIV/AIDS and personal responsibility. Other exposure visits targeted industries linked directly to some of the skills taught. For instance, a clothing factory was visited to interface with the tailoring course.

Following the successful implementation of *Operation Paseli*, there was a clear reduction in the number of young girls on Paseli Road at night. In due course, a number of those rehabilitated assumed social stability in society and have since been agents of change. Three graduation ceremonies eventually followed the successive completion of training programmes (numbers graduating were 30, 70 and 90 respectively). A subsequent class at one point reached as high as 100 in attendance. Almost at the same time as the street outreach that birthed *Operation Paseli* commenced, we witnessed that a new face of HIV emerged somewhat by default. It was later to be known as the *Lazarus Project.* Representing another notable experiential landmark in my research journey, here is how this phase unfolded.

1.3 The Lazarus Project: Providing Holistic Care To Orphaned And Vulnerable Children (OVCs), Their Families And Communities

Founded in 1999 through an initiative that began as a feeding programme conducted by my wife, Gladys, and the women of the Church, the Lazarus Project became a new window of insight into the devastating effects of AIDS as we were brought face to face with HIV infected and affected children living on the streets. Initial feeding sessions were conducted on Saturdays. They included teaching on various topics ranging from spiritual and moral teachings to personal hygiene and life-skills.

Following a rapid survey of 110 homes conducted in the main residential location from where the street majority of street children hailed, preliminary findings suggested the need to offer the children more than just monthly activities and meals. It became necessary to commence rescue efforts towards the provision of a more comprehensive rehabilitation programme that would include shelter, periodic medical check-ups, sustained nutrition and education. The first steps started with the rescue of six boys who were considered the most vulnerable children of those surveyed. These were immediately placed in a safe home that was rented for this purpose. The residential programme targeted boys only as they were more prevalent on the streets.

At this stage, the Canadian International Development Agency (CIDA) through the Crossroads Christian Communications (CCC) with whom we partnered from then on, made an initial 3-year funding offer that enabled exponential expansion to the rescue efforts. We proceeded to rent a 5 acre farm plot and immediately admitted 40 boys into the programme. The aim was to offer an opportunity for children to receive holistic transformation, progressively, through taught residential skills courses that included: spiritual formation, literacy training, skills training (carpentry, agriculture, poultry rearing), primary school education and recreation. Literacy and skills training was specifically designed for older boys who were beyond primary school entry age. To achieve this, we adopted a 3-pronged approach involving outreach, rehabilitation and re-integration.

In the course of time, we managed to secure a permanent residential facility on a spacious 40-acre farm with assistance of Crossroads Christian Communication who mobilized six Canadian businessmen to donate funds to help us secure an outright purchase of the property. More than 70 former street children were

immediately safely transferred and sheltered in the new facility. However, many of them were observably unwell.

While the younger children were more readily placed on ART upon being tested, it was difficult to get the older boys enrolled as the ethics required application of the full regime of voluntary counseling and testing (VCT). Where applicable, consent from traceable adult relatives was obtained before the affected boys could be placed on medication.

It is worth noting that it was difficult to ascertain veracity of personal information gathered from each child at recruitment stage regarding their background, HIV status or specifically whether they were AIDS orphans or nor not. The children were often bashful and secretive. Therefore, relationship building to cultivate trust was a priority at the very start. Coupled with it, was a vigorous family search program, through which relatives of most of the rehabilitated children were eventually traced. This enabled the children later to be re-integrated back into society after successful standard family conferencing procedures. Treatment options in the case of those needing the service were more assured in such cases.

From 2004, and for a successive period of three years, the Lazarus boys recorded 100 % pass rate for grade 8 national qualification examination classes, held at seventh grade, with two boys being ranked among the top two highest scoring students in their respective schools. Following the *phase-out* of the residential programme, the Lazarus activities are now focused on operation of an on-site Community School, the Lazarus Project Christian Community School. This has 400 orphaned and/or vulnerable boys and girls currently enrolled in primary school classes, running from grade 1-7 and staffed by a team of seven full-time teachers. The educational outreach, beyond the initial target group of street children, has

enabled the expansion of the school to cater generally for other vulnerable and disadvantaged children from the surrounding poor communities, to meet the rising demand for quality education nationally.

Studies have shown a linkage between poverty and lack of access to basic services such as education as a factor that predisposes children to risky life styles. However, this has to be understood within the context of the complex matrix that surrounds the definition, let alone the measuring, of poverty. Hence the Poverty Reduction Strategy Paper for Zambia observes: "The Zambian measurement has also not fully factored in such basic needs of the people as shelter, education, health care, lighting, clothing, footwear, and transport. Human freedoms are also remotely linked to the current definition of poverty."[7]

Against all odds, by the end of 2005, more than 50 children had been successfully re-integrated. Others were simultaneously placed in the church-owned primary school as well as various government schools until 2010 when the enrolment into the residential rehabilitation programme was phased out to pave the way for the establishment of a community primary school facility (referenced above) following the success of the re-integration programme. This enabled children not to be separated from their home roots. The children then remain the main link to their parents and households for the Lazarus social workers, in collaboration with COH community outreach team, to offer VCT and ART services where necessary, and provision of holistic care and support for them and their families.

To date, nearly 1000 orphaned and vulnerable children have undergone training, registering amazing stories of transformation. One of the most outstanding

[7] Zambian Poverty Reduction Strategy Paper- 2002-

graduates from the programme is now in his third year of Medical School at Zambia's prime University Teaching Hospital, Ridgeway Campus. Another boy, who completed high school with distinctions in Sciences and Additional Mathematics, has completed a Bachelors Degree in Accounting and Production Management studies at Zambia's Copper-belt University and is an active member of the Youth ministry at our church.

1.4 An Opportunity Offered Jointly by The Salvation Army And The UNAIDS (1999-2005)

In September 1999, I was one of 46 participants drawn from 19 countries, representing Churches, Christian faith-based Development Organisations and some grass-root level community groups. Through the communication that preceded the Consultation, we learned that the initiative was first mooted in 1997 to the Salvation Army's international facilitation team leader Captain (Dr) Ian Campbell by the then UNAIDS Senior Programme officer (NGO liaison) Calle Aimedal. Prominent in the convening documents was the call that it was time for:

> an expression of collaborative community-based response by Christian church leaders, especially in Africa, yet also with the view that churches in the south can be advocates with their sister churches in the north. Therefore an awakening of conscience, compassionate commitment and action was the chief purpose of the consultation.[8]

While funded by UNAIDS, the event which carried the theme *"Journey into hope"* was hosted in Gaborone, Botswana by the Botswana Christian Council. True to one of the key aspirations of the Consultation, *to awaken conscience,* the occasion

[8] https://www.salvationist.org/intnews.nsf/vw_web_articles/8536EFC2FBCD484E80256C00003160B1?opendocument. Salvation Army news. Accessed 14 May, 2015

was in every sense of the word an "awakening" of my own conscience to various emerging realities of HIV/AIDS. Subsequently, the quest to deepen my personal understanding of the epidemic grew and the design and set up of the Consultation aided this process immensely.

1.4.1 The Kibera Experience

Immediately prior to the said Consultation, participants were placed in groups of five to six persons and assigned to undertake respective 2-day exposure visits to four different countries within East Africa. The purpose of these visits was "observing and experiencing the local home and neighbourhood reality, reflecting together on the strengths seen, the challenges facing people affected by HIV and the effort to form some pathways into a more secure future."[9]

The team I was a part of was assigned to visit Uganda and Kenya. In Kenya, the chosen location was a high-density residential area called *Kibera*, considered to be Africa's largest slum. A leader of the Salvation Army congregation right at the heart of the slum received us into the Kibera community. He informed us that Kibera housed one million of the 2.5 million slum dwellers of Nairobi and that shockingly they had no formal supply of water or sanitation services. We observed upon entry that there were no streets, street lighting, police or medical facilities. Instead, we saw walking paths littered with trash, garbage and human waste.

The Salvation Army leader showed highlights representing success stories of his congregation's HIV outreach into a community brutally divested by the pandemic. We learned that "66% of girls in Kibera routinely traded sex for food by the age of

[9] Ibid

16, and many begun at age 6." It was also estimated that young women in Kibera contracted HIV at a rate 5 times that of their male counterparts and the latest estimates are that "only 8% of girls in Kibera have the chance to go to school."[10] In preparation for the house visitations we were cautioned to look out for "flying toilets" as it was said to be fairly routine for Kiberans to defecate in plastic bags and throw the same 'in the air,' as far as possible, regardless of where it landed. Reportedly, the sanitation challenges in Kibera persist to this day. It is estimated that there are approximately 600 toilets only for the entire population in the slum; meaning, a single toilet serves 1,300 people![11]

Shortly after the briefing, we were guided into selected homes of patients on the home-based care programme of the Church. Here, I came face to face with some of the grimmest images of AIDS sufferers. Later that night, the images lingered on as I reminisced over the day's activities. At midnight, I got out of bed and begun to write impressions and observations to share later at the impending Botswana consultation. Also that night, a series of biblical sermons I titled *"death, dying and grief"* (dealing with the Christian response to HIV related deaths, which I later preached in the church over a 3-week period) were born.

The quest to learn more about the exemplary congregational work of churches like the Salvation Army Church grew even deeper. Along with it grew the desire to do more personally in the fight against HIV. I wondered whether there were other congregations doing this kind of outreach in the health and social sector and if so, how effective they possibly were. The Kibera experience became a significant turning point in my engagement with HIV/AIDS work. What could be

[10] http://kiberalawcentre.org/facts/ Accessed 15 March, 2015

[11] Ibid

done to engage a church congregation to the level of awareness and action evident in this Salvation Church that was preaching hope in the midst of hopelessness?

1.4.2 The Botswana Reflective Sessions

Upon completion of the exposure visits, all Consultation participants reconvened in Gaborone, Botswana. We were guided into a process of "concept analysis"[12] that became the foundation of the consultative discussions that followed. Key concepts of *'care and community,' 'loss, hope and the future' and change'* were explored on successive days of the consultation. The central theme of *Hope* was associated with "acknowledgement of profound loss that [was] affecting families, communities and churches."[13]

The methodology involved an experiential learning approach, sharing reflections on the experiences in the respective communities visited during pre-consultation exposure trips. The "voices of a nation" [14] and neighbourhood perspective were heard from a family including a married couple, both with AIDS, along with their senior headman from the village, in the southern province of Zambia, near a Salvation Army owned Chikankata Hospital, renowned for the birthing and popularisation of community home-based care for AIDS patients. Then there was further sharing of other family stories, one of which was told by Dr Waza Kaunda, son of the first President of the Republic of Zambia, Dr Kenneth David Kaunda.[15] These stories were then linked to relevant and applicable theological foundations.

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[12] https://www.salvationist.org/intnews.nsf/vw_web_articles/8536EFC2FBCD484E80256C00003160B1?opendocument. Salvation Army news. Accessed 14 May, 2015

[13] Ibid

[14] Ibid

[15] President Kaunda had been the very first Zambian political leader at such a high level to acknowledge the HIV pandemic publicly by disclosing hat one of his sons had died of AIDS.

At the end of the Consultation, I was selected to be part of a regional resource/facilitation team led by Macdonald Chaava of the Salvation Army. One of our main tasks was to "respond to specific local organisational requests for support"[16] as the vision had been clarified within the context of 'community capacity development.' [17] Between 2000-2005, the facilitation team conducted numerous capacity-building trainings in church congregations and Christian development organisations within the Southern African Development Community (SADC) region.

Personally, the *journey into hope* and the quest to know more and do more in respect to the Church response to AIDS was given further impetus. I witnessed, first hand, the immense potential that lay in church congregations to help turn the tide of HIV/AIDS. Paradoxically, yet so visible also was the glaring inaction and lack of knowledge regarding the AIDS pandemic. Some congregation leaders we visited confessed never having thought that it was within the Church Mission mandate to do anything about HIV/AIDS at all. They genuinely argued that it was only for scientists and health professionals who were deemed experts in the field.

Upon returning home, I commenced preaching the 3-part series of sermons on *death, dying and grief* that had grown directly out of the defining experience in Kibera. Following that, I instituted a weekly (evening) bible study session attended by an average 250 of our congregants, and which ran for six months, exploring the topic- *A Christian response to HIV/AIDS: A biblical perspective*. While I concentrated on the biblical import, I requested two medical doctors and a nurse to take turns in teaching the clinical aspects of the disease.

[16] Ibid
[17] Ibid

The sessions were designed deliberately to be interactive and therefore succeeded well in raising awareness regarding HIV/AIDS and essentially broke the silence that surrounded AIDS related matters. From then on up to 2003, my personal social engagement and that of the congregation through the three main AIDS interventions (*Lazarus Project, Operation Paseli* and *Circle of Hope*- as discussed in separate sections) grew rapidly to levels of national and international recognition.

1.5 The Wider Picture: Church Congregations

During 1999, Dr Helmut Reutter of the GO Centre[18] and I begun actionable discussion towards harnessing the untapped potential in Church congregations to fight HIV. The next section chronicles briefly our observations as narrated also in Woolnough (2013) and here representing a third precursory phase to the current research.

1.6 Re- Tracing the Church's Involvement in AIDS Work in Zambia: CHAZ

As in most affected countries, National AIDS response in Zambia traces its beginnings in the health sector. The Zambian church's involvement in the health sector notably predates known specific HIV/AIDS interventions, since its health interventions generally go as far back as the early 1800s.

[18] A Christian Ministry that pioneered innovative faith-based AIDS responses in various peri-urban communities through the provision of periodic mobile Voluntary Counseling and Testing (VCT) services.

The church's efforts in the sector are attributable initially to the Churches Health Association of Zambia (CHAZ, formerly CMAZ, established in 1970). At present, the Church's coverage in this respect, represents approximately 35% of Zambia's total general healthcare provision, in general and approximately 60% of Zambia's rural health care provision, in particular. This is well within the WHO estimation that FBOs provide between 30-70% of health care services in Africa.

CHAZ is operated under the joint auspices of four major Church bodies namely: The Council of Churches in Zambia (CCZ), the Evangelical Fellowship of Zambia (EFZ), the Zambia Episcopal Conference (ZEC) and the Seventh Day Adventist Union (SDA) Zambia Conference.

There are 3 distinct phases to the progression of the Church in relation to HIV/AIDS: The *early days* (1984-1990), when issues like HIV/AIDS were avoided on the pretext that they were purely medical and had little relevance to the spiritual mandate of the Church; the *awakening of a latent conscience* (1991-2000) and the *constructive engagement of church congregations* (2001 to the present), when a greater level of the understanding that the gospel is holistic, caring for both body and spirit, was accepted. A number of Church congregations, including our own (Northmead Assembly), now demonstrate in more ways than one, that evangelism and social action should not be separated.

1.7 The Expanded Church Response (ECR) to HIV/AIDS Trust

As sporadic Church-based initiatives, involving the Church congregations themselves, emerged, it became clear that a mechanism was needed to coordinate these noble efforts. It was undeniable that there was a gap to be filled.

The Expanded Church Response (ECR) to HIV/AIDS Trust was formed in 1999 to fill that gap. Working with Dr. Helmut Reutter, and with the financial support of World Vision Zambia, we mobilized 220 Church leaders to discuss the dire need for collective action to confront the HIV/AIDS pandemic. One outcome was the formation of a Task Force (team) that I was privileged to chair. Later on, we registered (2003) as a legal trust, with the mission of coordinating faith-based AIDS responses and with the hope that it would become a conduit for channeling global resources to churches. Up until this point there were general questions from donor agencies about church congregations' capacity to handle large financial resources.

By 2013, The ECR was managing an annual budget in excess of US $1.5 million. It has cumulatively built the capacity of hundreds of Church leaders, congregations and more than 94 Faith-based Organisations (FBOs) and health facilities. This has resulted in the following milestones:

- Over 30,000 Orphans and Vulnerable Children (OVC) reached annually with education; health; psychosocial; food and nutrition; legal and protection; economic strengthening; and shelter and care.
- Over 10,000 people reached annually with ART adherence support, Home Based Care (HBC), TB adherence, Voluntary Counselling and Testing (VCT), Awareness Prevention Mother to Child Transmission (PMTCT)
- Over 10,000 youths reached with HIV prevention messages through promotion of "Abstinence and Be Faithful" messages

The great advantage of ECR, which includes working with more than 16,000 individual churches and millions of potential volunteers, is its ability to harness this high volume of human resource, coupled with the ability to act through established infrastructure, already existent throughout the Churches. For instance, large

Evangelical/ Pentecostal Church denominations like the Pentecostal Assemblies of God Zambia (PAOG-Z) to which Northmead Assembly of God's Circle of Hope Family Care Centre is affiliated, have over 1800 congregations spread across the country. The congregations are divided into 6 administrative Districts and run schools along with various community outreaches. In 2002 the congregations were formally directed by the Governing Council of Bishops to ensure provision of HIV/AIDS awareness training as a matter of on-going Church policy. Accessing such established congregational or institutional channels is particularly effective in the rural areas, where NGOs, especially those spread over multiple countries, have considerable difficulty reaching. A similar case in point is one in which, from 2006 to 2012, ECR worked on HIV/AIDS responses through multiple denominations and in diverse geographical areas on account of key partnerships with the Catholic Church, Salvation Army and others in 24 districts and 5 provinces of Zambia.

Over time, the ECR has also managed to grow a highly qualified team with extensive experience and a history of successful grant management. What ECR has achieved since its inception is testimony to the strength, capacity and overall comparative advantage of the Church as a key player in the AIDS fight, while delivering life-saving services and development, in a sustainable manner. Sustainability of these efforts is anchored in the assured perpetuity that lies in local Churches, as they are in the community for long term good.

In 2014, following an RFA[19] announcement, ECR demonstrated its growth as local organisation by winning a $24 million grant programme namely, the Zambia

[19] A Request Funding Application (RFA) is a formal statement that solicits grant or cooperative agreement applications in a well-defined scientific area to accomplish specific program objectives. An RFA indicates the estimated amount of funds set aside for the competition, the estimated number of awards to be made, whether cost sharing is required, and the application submission date(s). For cooperative agreements, the RFA will describe the responsibilities and obligations of NIH and

Family (ZAMFAM) to be implemented over a period of five years. The project, which focuses on Orphans and Vulnerable Children, is funded under the President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID). Its overall goal is to improve the care and resilience of vulnerable populations. It targets all the eight districts of Lusaka Province and ten districts of Copper-belt Province, to provide care and support to children and family members living in vulnerable households affected by HIV/AIDS.

In this instance, ECR as a prime partner is working together with two other Zambian local organizations called Zambia Open Community Schools (ZOCS) and Serenity Harm Reduction Program in Zambia (SHARPZ) and an international NGO, Catholic Relief Services (CRS) in partnership with the Government of Zambia, Community schools, and various faith-based and community-based organizations (CBOs).

Most of key developments during the foregoing phase took place almost simultaneously with some key policy occurrences that shaped the next precursory opportunity: participating on the National AIDS Council Board.

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awardees as well as joint responsibilities and obligations. A Scientific Review Group (SRG) specially convened by the awarding component that issued the RFA usually reviews applications submitted in response to an RFA. (http://grants.nih.gov/grants/glossary.htm#RequestforApplication(RFA).

1.8 An Opportunity Offered by The Government of the Republic of Zambia (2003-2014)

On May 5 2003, the Government of the Republic of Zambia through the Ministry of Health appointed me to serve on the Board of the National HIV/AIDS/STI/TB Council (NAC). The NAC was established in December 2002 through an ACT[20] of the Zambian Parliament as a broad-based corporate body with government, private sector, civil society and faith-based representation. It is mandated to coordinate, monitor and evaluate inputs, outputs and the impact of HIV/AIDS programmes and interventions.

The Council is supported by the NAC Secretariat, whose role is to implement Council decisions, including the development of technical guidelines for the effective coordination of a national multi-sectoral response. The Director-General, who is the Chief Executive Officer answerable to the Council while serving as Secretary to the same, heads the Secretariat.

In September 2007, I was further appointed Board Chairperson of the NAC, a position in which I served for seven years till August 2014. The role included quarterly sittings on the Zambian Cabinet Committee of Ministers on HIV/AIDS to which I was Secretary (assisted by the NAC Director General). The Honourable Minister of Health chaired the Committee, which in the 2011 realignment of Ministries was renamed the Cabinet Committee of Ministers for Health and HIV. Engagement in HIV work at this high level exposed me to significant policy considerations that are highlighted further and interrogated in this research.

[20] National HIV/AIDS/STI/TB ACT number 10 of 2002

1.9 An Opportunity Offered by USAID-Funded Family Health International's (FHI) Impact Programme (2003-2005)

IMPACT (Implementing AIDS Prevention And Care), an HIV prevention initiative funded by USAID through Family Health International (FHI) was, in 2003, considered the *"largest and most established"* [21] non-profit organization active in international public health. It ran 37 offices worldwide and was addressing infectious disease and reproductive health in 70 countries. On record, from 1997 to 2007, IMPACT reached more than 75 countries with programmes that focused on four priorities: 1) Reducing HIV transmission in large segments of the population; 2) Reducing morbidity and mortality due to HIV/AIDS; 3) Improving the quality of life of the majority of people living with HIV/AIDS; and 4) Mitigating the impact of the epidemic, especially on orphans and other vulnerable children.[22]

I accepted to serve on the Technical Advisory Team of this leading United States Government Contractor, which in fiscal year 2005, "reported $224 million in revenue, $206 million of which came from United Sates of America government grants"[23] inclusive of $100 million from PEPFAR.[24]

My role on the team included advising FHI head office in Arlington, Virginia on the implementation of relevant HIV/AIDS policy internationally, especially in relation to FHI's cooperation with Faith-Based Organizations (FBOs). At one of the board meetings held in Arlington, barely six months after the launch of PEPFAR, a

[21] http://www.publicintegrity.org/2006/11/30/6396/family-health-international
[22] Ibid
[23] Ibid
[24] The Presidential Emergency Plan for AIDS Relief launched by President George Bush in May 2003 targeted 15 countries, 12 of which were in Africa while the other 3 were Guyana, Haiti and Vietnam.

named team member, actually a professor representing a leading academic institution in the USA expressed his disgust over churches and other FBOs, particularly in Africa, for what he termed an ideological approach that was largely woven around "silly initiatives" while they attempted to combat HIV/AIDS. Incidentally, the reaction was to a report indicating a sudden surge in AB interventions in a number of target countries following the launch of PEPFAR. He charged that in most cases churches and FBOs told many wonderful stories yet were hardly documented and therefore lacked empirical evidence. "Let us stick to what has been proven to work," he added, clearly referring to the C (condoms) in the ABC matrix.

Being the FBO representative on the team, I was compelled to respond. While acknowledging the apparent lack of documentation for some interventions undertaken by many churches and FBOs, I pointed out that it was inappropriate for a policy maker at this level to stigmatise FBOs. I went on to suggest that rather than put labels on one another, more experienced organisations in the global north ought to have been looking at strategic partnerships with FBOs in the global south with the view to build their capacity in areas of apparent weakness. It was best to assist them document their stories. The point was taken with magnanimity to the extent that during a break time that followed this rather tense session, a positive conversation ensued in which the professor extended an open invitation for me to speak at their institution the next time I would be in the USA.

The call for documentation and empirical evidence opened my eyes to the need for research in many key areas of the churches' endeavour in the AIDS response. I purposed in my heart that rather than being 'defensive', it was best to heed this call in some way and bridge the evidence gap by investigating further and

critically assessing the important work of the church in this respect. After 5 years of more alert engagement in efforts towards documentation of churches' interventions, I was partially motivated by the foregoing encounter with the said professor, in the hallways of FHI, to embark on the current study.

We turn next to the central location for the study, Circle of Hope (COH) and consider a brief history of its formation as well as an overview of its operational model and scope of programmatic activities:

1.10 The Circle of Hope (COH) Family Care Centre (2003-Date)

The Circle of Hope (COH) Family Care Centre is a congregation-based initiative of the Northmead Assembly of God (NAOG) Church, providing treatment and care for HIV/AIDS and promoting abstinence and marital fidelity. The centre is situated in Makeni, 8 kilometres South West of Zambia's Capital City, Lusaka, in a residential location of predominantly low-to-middle income households with a population of over 15,000. COH provides free Voluntary Counselling and Testing (VCT) services along with the provision of Anti-Retroviral Therapy (ART) for People Living with HIV/AIDS (PLWHA).

1.10.1 History of COH as a Congregation-Based HIV/AIDS Support Group

The COH initiative was founded in 2003 following 8 years of growing personal pastoral involvement with church members, who voluntarily disclosed their HIV positive status and the need for care. These individuals also expressed a deep longing for interaction with other seropositive persons.

In August 2003, my wife and I embarked specifically on one-on-one talks with each individual church member who had so far disclosed his or her status. In these conversations, we sought their consent for us to make a public announcement calling for all those who had individually approached us kindly to come for a gathering at our home on a given Saturday, with the intent of meeting others who were eager to see the formation of a support group. Following the announcement, sixteen women and one gentleman came for the gathering, on the said Saturday. What was evident was that all of them were seeing each other, in the context of HIV, for the very first time!

We took time to explain the background and purpose of the gathering and the need for them as PLWHA to form a support group. Thus, in November 2003, in the back yard of our home, the COH was formed as a congregation-based support group for persons living positively with HIV. The group soon grew from seventeen to nearly one hundred people that met regularly to devise strategies to complement care and treatment ideals with prevention of HIV/AIDS through the promotion of sexual abstinence and marital fidelity, maintaining the congregation as their main anchor base.

1.10.2 Circle of Hope (COH) Family Care Centre Clinic Established

Later, COH Family Care Centre was established in September 2005, to address growing needs for HIV/AIDS treatment and care, including the provision of voluntary counselling and testing (VCT) and anti-retroviral therapy (ART), in partnership with the Expanded Church Response (ECR) to HIV/AIDS Trust. COH has counselled and tested cumulatively (as at December 2014) 11938 people out of

which number 5326 (including 258 children) are currently enrolled for anti-retroviral treatment and care. Approximately 80 people per day visit the COH Centre while 120 patients are enrolled monthly.

Enrolment entails that one undergoes voluntary pre-test and post-test counselling. For people who are found HIV positive, with a CD4 cell count of 500[25] or below, immediate treatment is commenced, with an offer of one month's supply of medication. From then on, they return to the Centre once a month, for review and further medication. Before their return to the Centre, they are visited individually by the COH Adherence and Outreach team. Volunteers also provide home-based palliative care as needed.

1.10.3 Circle of Hope (COH) Operational Set Up

A Senior Management Team (SMT) comprising of a National Facilitator, National Coordinator, National Programmes Manager, Head of Medical Services and the Finance & Administration Manager staffs the COH. Professional medical personnel include doctors, nurses and laboratory technicians. The staff team has a number of trained and certified counselors who handle the VCT. There is also a full complement of professional data and records team as the Centre runs on a syndicated international information management system to manage adequately and robustly the highly complex patient treatment tracking, bearing in mind the thousands on treatment.

[25] The international (WHO) minimum CD4 cell count for treatment eligibility was raised fro 200 to 300 in 2009 and now stands at 500

The SMT provides leadership to the organisation and has the primary responsibility for the execution of the organisation's Strategic Plan. The National Coordinator runs the day-to-day operations of the clinic and is the head of management. The SMT is answerable to a Governing Board, which is appointed by the NAOG Advisory Council as in Figure 1 Below:

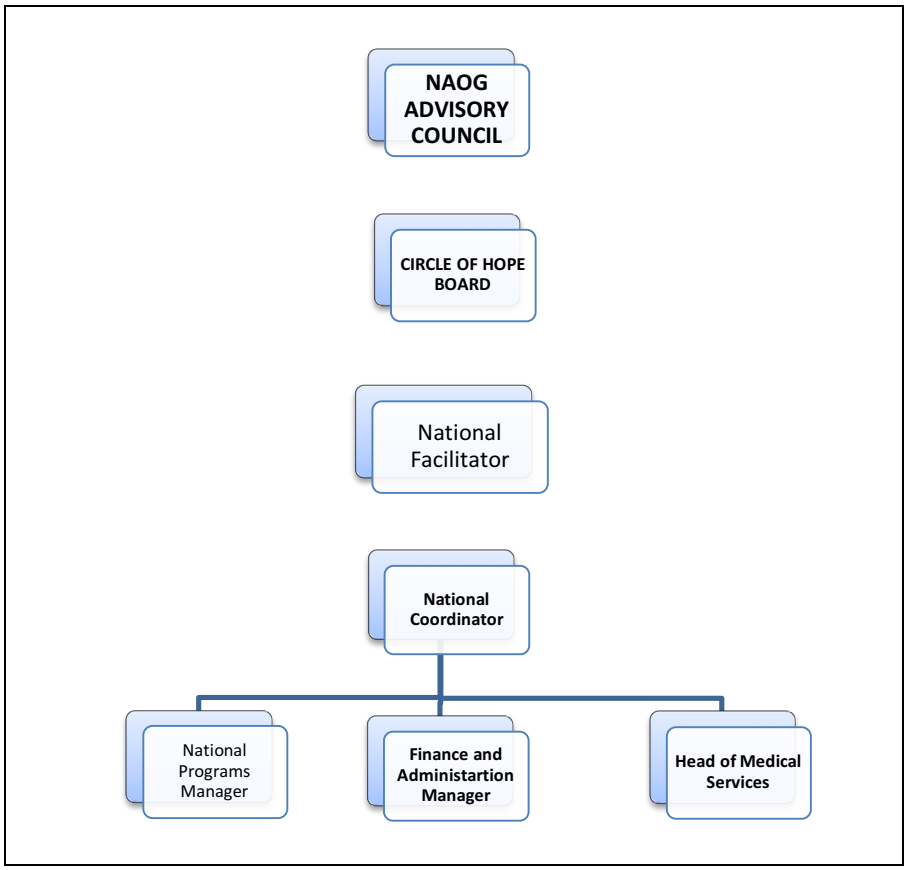

Figure 1: COH Governance Structure

As a recipient of international financial resources including government funding, COH functions transparently. It has been subjected to a Site Capacity Assessment (SCA) tool by the Human Resources Services Administration HRSA (2011), an Agency of the US Government, to ascertain the effectiveness of COH's

systems in the Administrative, Finance and Medical Functions and obtained a high score.[26] Its medical facilities include a pharmacy, laboratory, and diagnostic room with X-ray machines and all the minimum equipment stock for a fully-fledged ART Centre clinic at its level. These facilities are subject to annual standard inspections and certifications by the Health Professionals Council of Zambia (HPCZ). Tables 2 and 3 show what was observed on record at the time of the study.

Table 1: Assessments of Medical Standards

ASSESSMENT	**DATE**	**ASSESSOR**
Consulting room	Aug 2005	Medical Association Of Zambia (MAZ)
ART ACCREDITATION	OCTOBER 2007	Medical Association Of Zambia (MAZ)
X RAY ROOM & USAGE CERTIFICATION	JULY 2009	Radiation Control Board (RBC)
TB Screening capability	2012	Health Professionals Council Zambia (HPCZ)

[26] HRSA report is available for reference

Table 2: Vision Statement

Vision

To be at the center of providing high quality medical treatment, care and preventive interventions for HIV/AIDS and associated diseases for improved quality of life to the infected and affected in Zambia and beyond.

Mission:

To provide high quality medical treatment, care and preventive interventions for HIV/AIDS and associated diseases leading to improved and enriched quality of life to the affected and infected in Zambia and beyond.

Core Values (SCALE ~ T)

Service	offered to all without partiality, bias in a predictive way
Credibility	in carrying out its treatment, care and sensitization functions with all stakeholders in a professional, predictable and above reproach manner.
Accountability-	to all funders and other stakeholders in order to strengthen confidence levels and thereby foster continued flow of resources.
Leadership	from the whole team based on participatory engagement of various levels of leadership underpinned by a robust top down & bottom up communication regime that values feedback as a means of learning from the past.
Empathy	to be exhibited in the execution of service across the value chain for sustained performance levels.
Teamwork	in accomplishing tasks and assignments in order to promote Good attitude, skill & knowledge sharing, ownership and cohesion.

In conformity with the national vision of reducing the rate of new infections, improving the quality of care and treatment for PLWHA, COH has, over the years, scaled up its scope of strategic engagement in the communities and

catchment areas actively being served. The symbiotic relationship that exists between improved community sensitisation and improved adherence and prevention of new infections needs to be harnessed and leveraged further. This is against a background of noticeable reductions in national statistics in specific societal sectors and age groups, and notably the positive results posted in the PMTCT program.

As a direct strategic response to its national environment, COH has extended its services to a satellite clinic site in a location called Mutendere, Chisamba (60 Kilometres north of the capital City) in Central Province of Zambia, with programing activities in three critical areas:

1. Programme for Prevention of Mother to Child Transmission (PMTCT)
2. Tuberculosis and Malaria prevention and treatment.
3. Couple, Family and Community Counseling and sensitization

1.10.4 Programme Activity Description

In an effort to respond to the harsh reality of the impact of the HIV pandemic to Zambia and the Southern African Development Community (SADC), COH has formulated a strategic response that aims to address the problem in a holistic programmatic manner.

This response has taken into account the external and internal environments and is based on overcoming any barriers to mitigating the epidemic's impact and harnessing opportunities through leveraging its strengths in order to manage current infection levels and reduce new infections. The following programmes are operated from the Centre in addition to a full range of on-site VCT and ART services.

1.10.5 Prevention of Mother -to -Child Transmission (PMTCT)

COH runs this service in accordance to the Ministry of Health MOH national protocol guidelines and thus contributes towards the country's attainment of the HIV/MTCT elimination goal by reducing the proportion of HIV exposed babies becoming infected to <5%. COH optimises the quality of PMTCT services whilst sustaining coverage of HIV counseling and testing within its Antenatal (ANC) services at 95% and above. This entails the provision of Counseling (CT) across all entry points to integrate HIV prevention, care and treatment services, including maternal and child HIV care and PMTCT, family-centered services with partner and family testing as part of treatment expansion.

At the time of this study, COH had, in its strategic plan, the goal to ensure that 75% of its primary level facilities have integrated ART and PMTCT services by end of 2013. This was expected to result in at least 80% of HIV+ pregnant women in the catchment area receiving a complete course of efficacious ARV regimens as per National guidelines.

COH targeted that by the end of the same period, it would be implementing integrated Family Planning and CT services for prevention of pregnancy for all HIV+ and those of unknown status in up to 70% of its HIV CT facilities.[27] This was to be complemented with the scale-up of integrated youth friendly sexual and reproductive health service delivery to reach 20% of its supported facilities as a strategy for primary prevention of HIV. To ensure that quality of services is sustained and all targets are met, COH conducts supportive supervision and

[27] It is noted though that with guidance and counseling, HIV+ mothers who desire to continue growing their family may do so, understanding that there are now sufficient scientific measures to administer in such cases so that the respective child is born HIV free.

mentoring on a quarterly basis to 100% of its supported sites. The afore-going measures will be tracked in a future study.

1.10.6 Community-Based Treatment Support (CBTS)

COH is engaged in community-based treatment support through community sensitization as well as building capacity for community-based treatment through trainings, skills building, role-plays, drama, and community action plan development. Its outreach programmes include the promotion of delayed sexual debut or secondary abstinence, fidelity, partner reduction and address related social and community norms as part of a balanced prevention message approach. The documents and records assessed show that COH sees the advocacy of abstinence for the unmarried and its benefits as a primary way of way of prevention of HIV for young people.

The home visits are the strength of the COH intervention. During home visits, the Outreach team ensures adherence of each patient to the treatment regime as well as commitment to the ideals of abstinence and marital fidelity, since those who have already tested positive for HIV are considered the best advocates for behaviour change and responsible sexual lifestyles. The key motivation here is for these individuals to avoid infecting others thereby lowering the incremental incidences of new infections.

COH does not engage in condom distribution. However, its Outreach team provides general public health information for allowable usage of condoms for discordant married couples and cases where both husband and wife are HIV+. This minimises re-infection that would otherwise lead to increased viral load. COH is able to do this because the Pentecostal Assemblies of God-Zambia denomination,

officially adopted a policy announced by its presiding Governing Council of Bishops in 2002, to their 1800 congregations nationwide, effectively sanctioning the usage of condoms for prevention of HIV infection or re-infection among discordant couples particularly in the context of marriage. COH collaborates its community work with the government and other agencies through the District AIDS Task Force (DATF) and District Referral Network Associations. To ensure family sensitive services, COH encourages partner notification through disclosure of HIV results by promoting couple counseling and testing services. Table 4 shows the funding sources on record at the time of the study.

As its local contribution, NAOG church has granted COH a large piece of land for the eventual construction of a first level District Hospital with expanded medical services for the surrounding communities.

Table 3: Sources & Levels of Funding

DATE	**FUNDER**	Zambian Kwacha ZMW **(5000:1US$)**- Exchange Rate at time of study
2/2/2006 -02/28/2007	Children's AIDS Fund-US/PEPFAR	783,798,396.00
06/ 2006	Churches Health Association of Zambia (CHAZ)	30,000,000.00

3/30/2007- 02/06/2008	Children's AIDS Fund-US/PEPFAR	1,447,938,531.60
3/10/2008-03/03/2009	Children's AIDS Fund-US/PEPFAR	1,952,554,384.00
3/12/2009-02/28/2010	Children's AIDS Fund-US/PEPFAR	2,535,869,904.00
3/01/2010 -02/28/2011	Children's AIDS Fund-US/PEPFAR	2,292,338,661.00
01/03/2011-02/28/2012	Children's AIDS Fund-US/PEPFAR	1,026,296,989.00
01/10/2011-30/09/2012	Children's AIDS Fund-US/PEPFAR	1,601,297,335.00

1.11 Cross-Cutting HIV Related Issues

1.11.1 The Human Rights and The Sexuality Debate: Is It the Most Effective Way to Respond to HIV?

Fairly early during this research project and later, in particular during the course of background reading preparation for a Consultation on Human Rights and Africa held in Abuja, Nigeria (July 2011), it emerged that the demand for a rights-based response to HIV was fast becoming one of the most referenced issues in the global discourse on HIV/AIDS. Allison Herling Ruark and Edward C. Green (2011)[28] wrote aptly:

[28] Edward C. Green was, until 2006, a senior research scientist at the Harvard School of Public Health and Director of the Harvard AIDS Prevention Research Project at the Harvard Center for Population

> The field of HIV/AIDS, like other health and development fields, is now dominated by a human rights-based approach. The rights championed by major donors such as UNAIDS and within the global AIDS activism community now include the right to engage in injecting drug use, prostitution, and other risky sexual behaviours. The language of rights has been appropriated to mean an individual's right to engage in nearly any activity he or she chooses, regardless of the risk or consequences to self or others. Support of any other position is seen as tantamount to committing the worst transgression in the AIDS world: making moral judgments.[29]

The practical reality of this scenario can be illustrated in the following moment experienced first hand by the author, on the floor of one of the world's most powerful global gatherings.

In June 2008, I was privileged to travel, for the very first time, to the United Nations General Assembly (UNGASS) High Level Meeting for Heads of States and other representatives of member States (June 10-12, 2008). In a capacity as Board Chairperson for the National AIDS Council on the Zambian delegation led by the then Honourable Minister of Health, my role was advisory but also included full participation in the deliberations as per assigned sessions.

One of the sessions featured a presentation from a lady Civil Society activist from an Asian country, who called plainly for the global recognition of prostitution as a "legitimate labour". This call sounded consistent with all too familiar global campaigns by a myriad of human rights groups, select non-governmental

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and Development Studies. He is the author of numerous books, edited volumes, and academic articles, including the seminal Rethinking AIDS Prevention: Learning from Successes in Developing Countries (Praeger, 2003). He has also published books and articles about indigenous knowledge and behaviours related to medicine and healing. Allison Herling Ruark was a research fellow at the Harvard AIDS Prevention Research Project, where she wrote and published on HIV prevention and the role of faith communities in prevention. Ms. Ruark, PhD (Johns Hopkins University), is co-author, with Edward C. Green, of The ABC Approach to Preventing the Sexual Transmission of HIV: Common Questions and Answers (2007), a monograph that is being used by numerous non-governmental organizations and by the United States Agency for International Development

[29] Green, Edward C., Ruark, Allison H 2011, 'Interrogating a Rights-Based Approach to HIV Prevention.' Paper Presented at *The Fellowship of Confessing Anglicans (FCA) Consultation on Human Rights*, Abuja, Nigeria**.** Based on a chapter in their book- *AIDS, Behaviour and Culture: Understanding Evidence –based Prevention, Left Coast Press, 2011*

organisations (NGOs) and various western UN member States who are known invariably to sponsor some of the lobby groups and advocates for human rights in the context of HIV prevention. The activist in current reference took a swipe at religious organisations and basically labelled them *guilty* of "moralising" generally and stigmatising specifically, "sex work," which activity she defended vehemently as legitimate.

My comments on the lady activist's presentation and the issues raised were essentially that global HIV/AIDS activists needed to recognise afresh and embrace the role of Faith Based Organisations (FBOs) in the AIDS fight. Further, there was need to avoid stigmatisation of religious and moral teaching as a mere 'moralisation' of HIV/AIDS. I then called for change in approaches undertaken when tackling HIV/AIDS issues in light of the observation then that Zambia was recording evidence (Banda 2000) of the significant positive impact of moral and religious teaching in the fight against HIV/AIDS.

I made, a specific indication that prostitutes (sex workers) were being reached and rehabilitated by FBO interventions, to the effect of demonstrating empirically verifiable behaviour change and leading to voluntary avoidance of risky sexual behaviour. Therefore, the generalised call for 'sex work' to be recognized as "legitimate labour" as declared by this participant in the Civil Society hearing of 10th June, 2008 stood misplaced.

1.11.2 Means-End Inversion

I proceeded to caution against a "*one-size-fits-all*" approach, specifically warning that it was inappropriate and untenable. This was followed by a call for sexual behaviour change that is based on the moral message carried by religious

organizations. And the fact that religious organizations and or churches promote sexual behaviour change as a lifestyle priority needed consideration as a hugely significant comparative advantage. Emphasis was made that organisations in the Northern Hemisphere needed to listen to local organisations (in member States) in the South such as those of us "working on the ground," noting that HIV policies must be evidence-based.

And on that score, a quest to ensure protection of the rights of sexual minorities cannot be undertaken at the expense of ignoring the moral and cultural specific values that make such practices abhorrent in some of the nations. The *end* can by no means justify the *means*!

A participant who sat in the terraces of the UN hall listening in to the afore-going exchange later posted the following observation:

> I am at UNGASS, and just heard your very powerful comments. I just wanted to applaud you for saying those things. I have been waiting for someone to make *any* mention of sexual behavior-- it is amazing how everyone gives the same comments over and over, and yet so much is not discussed at all. (I am here as a civil society observer, so don't have the opportunity to make comments anywhere.) FYI, I am sitting in the overflow room, not the main room, but there was enthusiastic applause from a number of people, mostly Africans. For those of you who I am copying and don't know what [author named] (of Zambia) said, here are my rough notes (and he is the ONLY one I have heard say most of these things): "What can be done to translate info into knowledge, and knowledge into behavior change? There are certain approaches that must change. There is lots of new evidence that must guide our programs. A one-size-fits-all approach doesn't work-- some things that I hear promoted as a one-size-fits all solution here will not work for Zambia. In Zambia, we have evidence that moral and religious teaching have played a very important role. We would like to put it on record that there is a role for FBOs and moral and religious teaching. We need sexual behaviour change, and moral and religious organizations can promote sexual behaviour change. Northern organizations need to listen to local organizations, to those of us working on the ground." I know that is very rough-- if you have a copy of your comments that you could share I'd love to have it. As a note to all of us, I was pleasantly surprised by this language in the 2001 UNGASS Declaration: "By 2005, ensure that a wide range of prevention programmes which take account of local circumstances, ethics, and cultural values, is available in all countries, particularly the most affected countries, including... [those] aimed at reducing risk-taking behaviour and encouraging responsible sexual behaviour, including abstinence and fidelity..." Had I had a chance to make a comment, I would have loved to ask the Assembly why there has been NO discussion of those kinds of

programs or that goal at this meeting. *Depressed at UNGASS (Allison[30])*

The sender of this email happened to be the co-author of the paper I responded to at the Abuja Consultation on human rights. A bit later, Dr. Edward C. Green, co-author of the Nigeria paper in reference also sent me commendations for the recorded comment. Green and Ruark's impassioned quest for different voices to be heard in the AIDS response is laudable. Indeed, there is need for a sustained, vigorous interrogation of the rights-based approach in HIV Prevention. They point out appropriately that while there are many valuable aspects to a rights-based approach to HIV/AIDS, "and an insistence on human rights has done much to save lives, for instance through ensuring access to treatment for those with HIV,"[31] they add fittingly that, "unfortunately 'human rights' in the context of HIV/AIDS has also taken on other meanings".[32]

This is especially evident in observable global interest the subject has generated. This research features illustrative evidence that practically substantiates some of the key concerns raised by Green and Ruark and particularly in which respects the rights based approach has taken on "other meanings." It affirms the conclusion that these manoeuvres have essentially been redefined "rights," in regard to which Green and Ruark stated further:

> "Behaviours such as prostitution, risky sex, and drug use are now deemed 'rights' by many of those working in HIV prevention, including by such organizations as the World Health Organization and UNAIDS, which is the United Nation's AIDS organization".[33]

At a United Nations Special Session of 8th -10th June, 2011, that was focused on universal access to treatment for HIV, nearly every Western State that made their

[30] Email communication, 8th June, 2010
[31] Ibid
[32] Ibid
[33] Ibid

statement to the General Assembly, included some sort of call for other member States to recognize the rights of gays, lesbians, transgender persons, bisexuals, injection drug users and sex workers, along with open demands that States where such practices are legally prohibited should decriminalize them. Evidently, negotiating a consensus document as a final outcome of the said session became very challenging. In the final analysis, out of 104 points in the political declaration from this sixty-fifth session of the UN General Assembly, *Point Number 29* read as follows:

> Note that many national HIV prevention strategies inadequately focus on populations that epidemiological evidence shows are at higher risk, specifically men who have sex with men, people who inject drugs and sex workers, and further note, however, that each country should define the specific populations that are key to its epidemic and response, based on the epidemiological and national context.[34]

Green and Ruark are correct in noting, "It is unusual (and possibly unique) for the political agenda of human rights to be elevated to a major theme for disease prevention, as it has been for HIV/AIDS."

In further reference to the UN session under current discussion, the Islamic Republic of Iran and the Arab Republic of Syria each raised well reasoned objections to *Point number 29* on the basis of well articulated social, moral and religious grounds. Surprisingly, some members of the August UN gathering booed the distinguished representatives of these States. On the other hand, when Brazil and Mexico each spoke in support of the furtherance of efforts to promote gay, lesbian, bisexual and trans-gender rights, a significant number of delegates presumably from the Americas and Europe spontaneously cheered and applauded. Shortly after that, a

[34] United Nations General Assembly, Sixty-fifth Session, Agenda item 10, Implementation of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS, Annexed to Resolution A/65/1.77, p.5, 8 June, 2011

representative of the Holy See (Pope) read a position statement of the Vatican that called for a preference of the promotion of abstinence over condoms in regard to prevention strategies. A section of the House, once again, booed loudly though the lady representative of the Holy See was undeterred in her delivery of the message.

1.11.3 A New Type of Stigma?

It is apparent that the biases against faith-based behavioural options still abide, despite the growing body of evidence that behaviour change is central to winning the fight against HIV. The danger with labels and stereotypes is that they tend to belittle, howbeit indirectly, some of the available epidemiological evidence favouring behaviour change approaches to AIDS prevention. Instead, the evident biases illustrated above perpetrate a subtle institutionalised stigma against prevention efforts and general programmatic strategies that may appear to be unconventional. In this respect once again, Ruark and Green's concern could not be timelier:

> In the same way, donor-funded AIDS programs have typically operated under the assumption that Africans and other non-Western people cannot make progress against AIDS without education, technology and aid in the form of Western-funded AIDS programs. Many HIV prevention programs have treated everyone as if they were sexually active and already engaging in risk behavio[u]rs, which were unlikely to change. Yet most unmarried African teenagers are not sexually active, and most African adults are not having multiple partners.[35]

Green and Ruark's concern is well founded, as it is confirmed, in Zambia's case, by the Zambia Demographic and Health Surveys of 1996, 2001 and 2007 which showed, comparatively, that there are signs that more young people (females 15-19; males 15-19) delay sexual debut and remain sexually abstinent for longer.[36] It may

[35] Ibid

[36] Zambia Demographic and Health Reports – *P* values from Gouws, *et al. 2008*

be useful minimally to place this finding against the well-known historical backdrop of early apprehensions that met promotion of abstinence and/or marital fidelity, both of which approaches gradually came under intense public scrutiny and criticism, as they were repeatedly dismissed as allegedly being "non-evidence based and unrealistic." Yet nothing could have been further from reality on the ground as revealed by the evidence cited earlier.

Necessarily, a number of questions arise: Could it be that time has possibly come for Western governments in particular, to look afresh at the evidence being generated from Africa? Could it be that there is indeed a moral norm that might be rightly acceptable to societies in the global South, to ward off the 'whirlwind' of sexual liberalism (see Chapter 6) and moral relativism by which the AIDS sector is now challenged? Could this possibly be signalling the need for a significant paradigm shift in global AIDS policies and imperatively so, since the spread of HIV/AIDS is predominantly through sexual means?

1.11.4 The Importance of Empirical Evidence

The above finding lends credence to the growing body of literature published in some peer-reviewed journals and in some cases even just anecdotal evidence, showing that "*abstinence* and *being faithful* (A&B) behaviours, especially the latter (i.e. mutual marital fidelity, partner reduction)" are precisely among leading factors that impact HIV prevalence and incidence rates at the population level (Green & Ruark 2006). [37]

[37] Green, Edward, C and Ruark, Allison, H 2006, 'Paradigm Shift and Controversy in AIDS Prevention' *Journal of Medicine and The Person*, Vol. 4 no1 pp. 23-33

A key concern then is that the expediency of the 'rights' agenda could overshadow genuine efforts by FBOs towards the reduction of new infections that essentially represent the epi-centre of the AIDS 'battle front.' A brief look at this aspect is necessary.

1.11.5 Grappling with High Incidence Rates

A case of primary focus and concern in Zambia is the high incidence rate of new infections despite a decreased general national prevalence rate from 16.8% to 14.3% (ZDHS 2007) and further down to 13.3% (ZDHS 2013-2014). In 2012, Adult HIV incidence stood at the rate of 1.6%. It has halved since 1990 and is generally estimated to be at a stable level. However, a detail of grave concern is the fact that HIV incidence is consistently higher in women than in men (ZDHS, 2002; ZDHS, 2007).[38] In 2009, an estimated 82,681 adults got newly infected with HIV **(**59% in Women, 41% in Men- See figures below). This is about 226 new adult infections per day. Thus, although HIV incidence has stabilised, the *absolute* number of new HIV infections follows an increasing trend due to the expanding population (HIV Epi-synthesis Zambia Report 2009).

For the year 2012, about 276 new adult infections were predicted per day. It goes without saying, that the projected increase in the annual number of new infections, despite the stabilised HIV incidence rate, pronounces the urgent need to reduce the adult HIV incidence rate below the current level of 1.6%. This calls for urgent re-prioritisation of prevention.

On the 7th of February 2011, I happened to be among a group of dignitaries invited to witness the dedication of a named new Embassy building in Lusaka,

[38] These data are further analysed in the Zambia HIV Epi-synthesis 2009

Zambia. I had been ushered into the 4th row of the arena for the function. On my immediate left sat the then Swedish Ambassador to Zambia, Her Excellency Marie Andersson de Frutos and on my right was then UNAIDS Country Coordinator Dr. Amaya Gillespie. Being Chairperson of the National AIDS Council at the time, many people I would meet ordinarily triggered conversations on the subject of HIV/AIDS almost instantaneously, soon following the minimal salutations characteristic of Zambian courtesy. That day was no exception. As we discussed the 'peaking' of the Zambian HIV epidemic, we equally bemoaned the consistently higher new infections in sections of the population as shown in Figure 2.

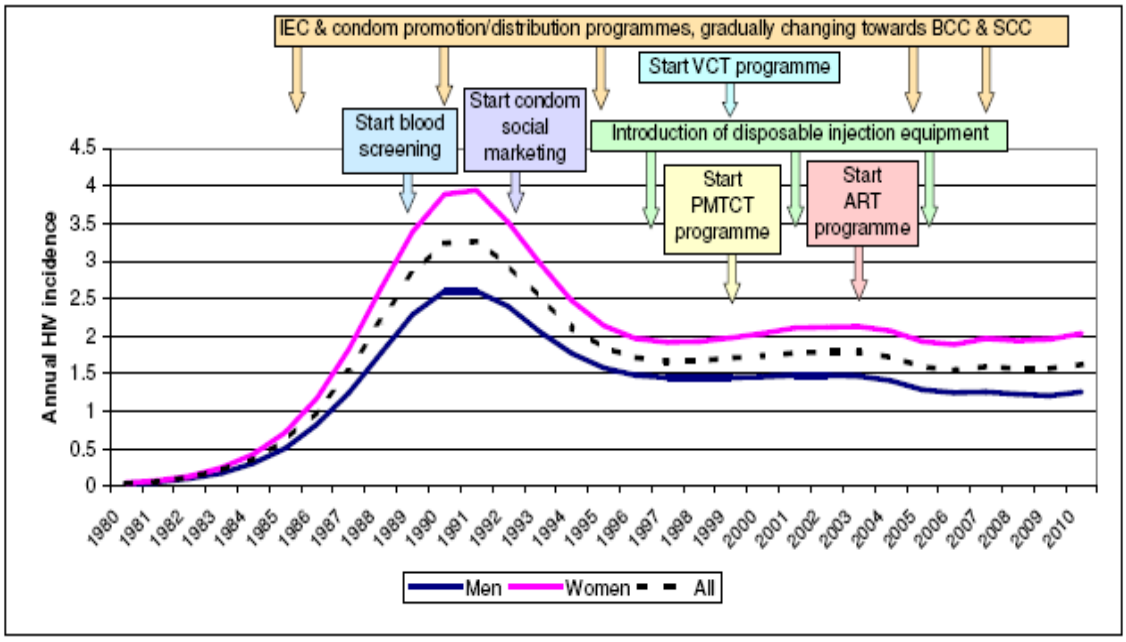

Figure 2: HIV incidence is consistently higher in women than in men- Source: CSO (2008)- HIV/AIDS projections report

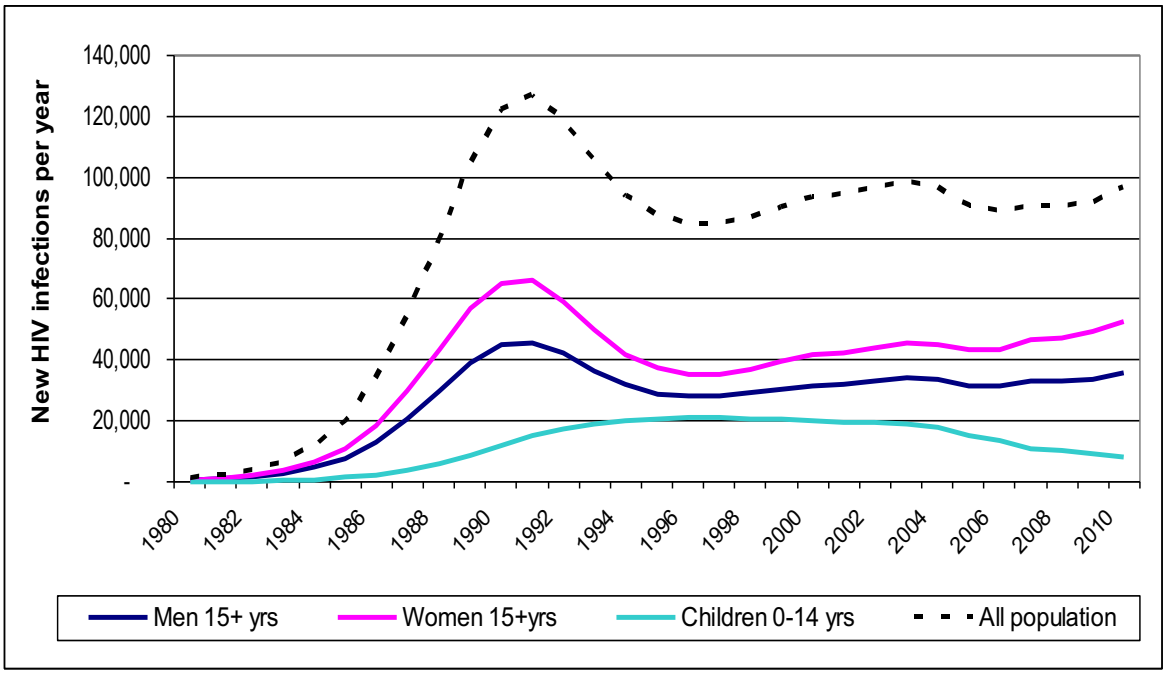

Figure 3: Estimated new HIV infections in Zambia (1980-2010) Source: CSO (2008) - HIV/AIDS projections report

Marie Andersson de Frutos[39] narrated how a cross section of Swedish society responded in shock when they learned that the 2007 figure for HIV infections in their nation was at 490, up from 312 the previous year, thus representing 108 new infections. Her remark was to the effect that "The nation was alarmed at this sharp rise in new infections,"[40]. Ambassador Frutos then made her point by observing comparatively that she still could not fully fathom the enormity of the burden of disease Zambia was having to grapple with, especially in view of the staggering 86,000 + new infections per year!

The three of us spent the following quarter of an hour discussing options regarding what could be done for the tide of new infections to be stemmed. We were

[39] Swedish Ambassador to Zambia (2008-2011, personal conversation, 7th January, 2011

[40] Swedish Ambassador to Zambia (2008-2011), personal conversation, 7th January, 2011

resolute concerning the urgent need to re-position prevention strategies at all levels.[41] Thankfully, some concrete follow-ups resulted from the discussion.[42] The afore-going interaction was also an encouragement for me to stay focussed on the current Study to make a needed contribution to the body of knowledge towards a reprioritisation of AB initiatives in the global fight against HIV. Could Zambia possibly reach the national goal (NASF 2011-2015) to halve the incidence rate by 2015?

1.11.6 Dealing with Messaging -The Need for Consistency

Talking about prioritisation of prevention, the message could not have been conveyed more succinctly and by no better a personality than a former head of State and at this time, Chairman of the National AIDS Council of Botswana, an incident that is recounted in Banda (2012) as follows:

> We had the rare opportunity to host former president of Botswana, His Excellency Festus Mogae, who apart from being my counterpart as Chairman of his country's National AIDS Council, is Chairman of Champions for an HIV Free Africa, a high level team composed of former African Heads of State and other eminent persons. While paying a courtesy call on the Zambian President Mr. Rupiah Bwezani Banda, Mr. Mogae said, "The number one priority in the fight against HIV/AIDS is *Prevention*." Then he went he went on to say," the number two priority is *Prevention*", and "the number three priority is *Prevention*!" I couldn't agree more.[43]

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[41] Banda, Joshua HK: *HIV/AIDS AND ETHNO CULTURAL FACTORS IN ZAMBIA: Do they fuel the spread or can they be anchors upon which to positively base the response? What could be the role(s) of the Church and Theology**?*** PacaNet, Jane Wambui Rosenow, ed., 2012.

[42] As a result of this conversation and further interaction, which has since included frank discussions on the rights-based approach (merits and demerits), Ambassador Frutos arranged a study tour to Sweden in October 2011. The visit involved dialogue with Civil Society groups, government officials and churches.

[43] Banda, Joshua HK: (*MCP- The Experience of the Church in MCP: The Evangelical Perspective* in "*Multiple and Concurrent Sexual Partnerships"- A Consultation with Senior Religious Leaders from East and Southern Africa.* Pan African Christian AIDS Network (PACANet), Jane Wambui Rosenow, ed., 2011, pg. 77

However, soon following that powerful comment, President Mogae went on to urge the nation of Zambia, in the interest HIV infection prevention, to consider decriminalising homosexuality, which at the moment is held as a criminal act under Zambia's Penal Code.

The response of President Banda was that he was personally baffled by donor countries' insistence on such an approach. He then added that while he understood that President Mogae made this call in the context of HIV prevention, he was personally concerned that the messaging in this respect is confusing to young people and hence his sense of perplexity by the said approach, which in his view was largely representative of donor countries' perspectives.

When called upon by President Banda to comment on the same, I had to employ tact while being candid. I commended President Mogae for coming to Zambia with a clarion call to prioritise prevention in the fight against HIV. However, I remarked that I was concerned that the important message of Prevention he had opened with was likely to be drowned out by his mention of the perceived need to decriminalise homosexuality, as the media (who were well represented on the occasion) were likely to highlight the subject of homosexuality rather than his intended 'top of the list' topic- *Prevention*. I gently argued that his earlier articulated message of Prevention now faced the danger of being lost.

And sure enough, the headlines in the local Papers the next day focused on the homosexuality item despite President Mogae's attempt through a strongly worded Press statement later at Zambia's Parliament, following the meeting with President Banda. In this Press brief, he laboured to clarify that he and the Champion's team were not in Zambia to promote homosexuality but rather call for the amplification and scaling up of HIV prevention at all levels. Clearly, the

newspapers had had their sensational scoop! This incident is self-defining in terms of where things are headed and particularly what the media craze is feeding into. It is a discourse that weighs heavily towards what funders appear to be placing at the head of the priority list for public advocacy on HIV globally- Key populations[44] (See chapter 8). The definition in itself is very important. However, on the ground, some funders often appear to narrow it down to men who have sex with men, sex workers and their clients, transgender persons and people who inject drugs. In most parts of Africa, this approach stirs up much controversy when it comes to funding proposals for the national response and what the programmatic priorities should look like.

1.11.7 Global Policy Challenges Ahead

Between 18-20 October, 2010, during the earlier mentioned visit of His Excellency Festus Mogae and in a scheduled meeting with Civil Society representatives, the following submission was number 1 on a list of 5 items the Civil Society wanted discussed with him:

> Legal and policy environment for Most at Risk Populations (MARPS)…there is a disconnect between the legal and policy environment: the penal code criminalises most behaviour the MARPS are engaged in i.e. sexual contact between members of the same sex, injection drug use, commercial sex work, etc.[45]

[44] According to UNAIDS Terminology guidelines- "The term 'key populations' or 'key populations at higher risk of HIV exposure' refers to those most likely to be exposed to HIV or to transmit it – their engagement is critical to a successful HIV response i.e. they are key to the epidemic and key to the response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender persons, people who inject drugs, sex workers and their clients, and sero-negative partners in sero-discordant couples are at higher risk of HIV exposure to HIV than other people. There is a strong link between various kinds of mobility and heightened risk of HIV exposure, depending on the reason for mobility and the extent to which people are outside their social context and norms. Each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context." UNAIDS advise against using term 'high-risk group' (Source: UNAIDS Terminology Guidelines 2011)

[45] Agenda and Notes in advance of Civil Society consultations with Chairman of Champions for HIV Free Africa

The text is self-evident. Proverbially, the 'writing is on the wall.' While the epidemiological and national context of many African countries may speak or demand otherwise, it is clear that it is the highly emotive issues of the sexual preferences and alternative sexual lifestyles that are more likely to continue topping the advocacy agenda in many African States.

Other human rights related topics likely to gain momentum include abortion rights and what is now termed 'comprehensive sexuality education' for young people, which to all intents and purposes is meant to aid them to access more accurate information and enhance understanding of the importance of sexual and reproductive health. The United Nations Population Fund (UNFPA) states the importance of comprehensive sexuality education as follows:

> Comprehensive sexuality education enables young people to make informed decisions about their sexuality and health. These programmes build life skills and increase responsible behaviours, and because they are based on human rights principles, they help advance human rights, gender equality and the empowerment of young people.[46]

However, once again, the reality on the ground often shows that many funded organisations have tended to overstate the human rights aspects. The result is an over-emphasis on sexual preferences in terms of orientation towards same sex relationships with discussions weighing towards the need to legalise them. Often, the argument is that criminalisation of these acts forces persons to go 'underground' in fear of being in conflict with the law, seeing that most African governments have relative prohibition clauses in their statutes. Directly or indirectly therefore, young people are being told to speak up on these matters.

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[46] http://www.unfpa.org/comprehensive-sexuality-education#sthash.wxr2Wihr.dpuf- Accessed 24 May, 2015

1.12 What are the Implications?

What do all these trends and actions really mean? Has the response to the HIV scourge become all about MARPS and nothing else? More questions then arise: is it not of concern that there are appears to be less and less emphasis on behaviour change in the face of HIV prevention and more on rights and preferences? Ought it not to be asked afresh why the promulgation of a highly charged rights-based approach to HIV prevention appears to be painting behavioural approaches with a broad brush, as passing value judgements? Given its rich cultural diversity and religious heritage, could Africa not do more to determine its own agenda in the struggle to defeat HIV? This level of probe might appear intrusive in space occupied by very powerful organisations. Is it so in reality?

On the other hand, it is actually confusing to observers who read the evidence and yet see actions and resources being directed practically in a totally different direction. In Volume 4, number I of the *Journal of Medicine and the Person* Green and Ruark (2006), captured this dilemma accurately and counselled:

> We wish to stress that we are not arguing for shifting attention and resources away from those at special high risk, including the powerless, oppressed, exploited, raped and abused. We *are* saying that it is inaccurate to characterize (all) Africans this way, and that we can no longer base *all* our AIDS prevention resources to this minority target group…What has been missing in this bitter debate is a calm, even-handed, balanced viewpoint that recognizes that *some* resources clearly *must* be targeted to high-risk groups, while *some* resources must be directed to what survey and epidemiological evidence show are the *majority* of people – Africans, in the context of this review. To do only the former is to effectively ignore most Africans in prevention efforts. Meanwhile to do both need not result in diminished quality or even quantity of prevention resources going to either group, the minority or the majority. It is only catastrophist, polemical, all-or-nothing thinking that would have us believe otherwise. If Uganda, with very few resources in the early years of its response to AIDS could design and implement a *balanced and targeted* ABC program, surely the major donors with billions of dollars can do the same.

One of the key lessons that stands out from Uganda is that early evidence that emerged from the actions on the ground became ground on which to build another

set of actions until the devastating impact of HIV begun to be contained and reversed. Evidence-informed actions therefore remain of prime importance.

Based on many years of exposure and experience in the HIV sector, the apparent challenge on the ground is encumbered by a clash of priorities between funding agencies and grant-recipient organisations, including governments in some cases. While there is a general call for equal 'partnerships at the table,' there is a growing discontent with unwritten conditionality attached to HIV assistance funds from certain donor nations. So, one asks whether this state of affairs represents the best form or posture for response to HIV at this stage.

The implications of the on-going duplicity are unimaginable. When dealing with human lives, the transparency and probity demanded of African States by donor Countries and Agencies must balance well on both ends of the scale, the aid-recipient as well as the donor. The principles of operation and 'rules of the game' must be unequivocally fair and just. The sheer dignity and worth of the recipient must be central to the equation of implementation. Then policies can be said to be just, the approach equitable and attendant measures contextually located, more assuredly beneficial and sustainable.

The precursors narrated in this chapter cumulatively grounded my desire to re- engage my own faith-based community, my congregation and particularly one of its constituent HIV Ministries – the COH with the intent to learn more about behavioural options of abstinence and marital fidelity in the face of the HIV national and global response so far, in order to make a contribution to the wider body of knowledge and help to save lives.

1.12 SUMMARY OF CHAPTER 1

The prolegomena chapter has provided the background, context and pre-cursors to the study. It has traced the genesis of the researcher's engagement in the HIV response, beginning with growing personal awareness through the loss of family as well as church members who died at of AIDS. The chapter then covers other highlights and key precursors that include strategic involvement with HIV policy advocacy and matters, nationally and globally, in the researcher's journey that culminated in the current study thus demonstrating the need to interrogate and learn from one's experience and praxis over time. The chapter details the evolving of COH (the central location for the study) as a congregation-based support group that grew into fully-fledged ART clinics now reaching thousands of people with comprehensive health services.

The next chapter explores the HIV situation globally, relevance, objectives and approach of the study.

CHAPTER 2: THE HIV SITUATION, RELEVANCE, OBJECTIVES AND APPROACH OF THE STUDY

2.1 THE GLOBAL HIV SITUATION

According to the Joint United Nations Programme on HIV/AIDS (UNAIDS) 35.0 million [33.2–37.2 million] people were living with HIV at the end of 2013, globally. Since the beginning of the epidemic, almost 78 million people have been infected with the HIV virus and about 39 million people have died of HIV. Also, an estimated 0.8% of adults aged 15–49 years worldwide are living with HIV. New HIV infections have fallen by 38% since 2001.

Worldwide, 2.1 million [1.9 million–2.4 million] people became newly infected with HIV in 2013, down from 3.4 million [3.3 million–3.6 million] in 2001. New HIV infections among children have declined by 58% since 2001, worldwide while 240 000 [210 000–280 000] children became newly infected with HIV in 2013, down from 580 000 [530 000–640 000] in 2001.

AIDS-related deaths have fallen by 35% since the peak in 2005. Specifically, in 2013, 1.5 million [1.4 million–1.7 million] people died from AIDS related causes worldwide, compared to 2.4 million [2.2 million–2.6 million] in 2005.

In terms of treatment, as of June 2014, 13.6 million people living with HIV had access to antiretroviral therapy. In 2013, the number was 12.9 million or 37% [35%-39%] of all people living with HIV. While, 38% [36%-40%] of all adults living with HIV are receiving treatment, only 24% [22%-26%] of all children living with HIV are receiving the lifesaving medicines. (UNAIDS Fact Sheet 2014)

Additionally, one of the ten UNAIDS co-sponsor agencies, WHO stated,

> although the burden of the epidemic continues to vary considerably between countries and regions, Sub-Saharan Africa remains most severely affected, with nearly 1 in every 20 adults living with HIV and accounting for nearly 71% of the people living with HIV worldwide.[1]

2.2 THE NATIONAL HIV SITUATION

2.2.1 Economic Overview

Zambia, in Southern Africa, has one of the world's most devastating HIV epidemics. In 2008 more than one in every seven adults in Zambia was living with HIV and life expectancy at birth was reported at 51.62 years. However, life expectancy increased to 57.04 years in 2012. That year, life expectancy for women was 58.70 years and for men 55.43 years (Countryeconom.com 2012).[2]

Zambia's economic buoyance, which expanded steadily after the attainment of political independence in 1964, begun to dwindle substantially in the mid-1970s following what is noted as a "sharp decline in copper prices and a sharp increase in oil prices." (ZDHS, 2013-14). The situation grew worse yet, in the 1980s when Zambia's poverty levels increased particularly impacted negatively by economic shocks following failed structural adjustment programmes (SAP). According to the Ministry of Finance and National Planning (MoFNP, 2013) report, Zambia's economic recovery programme implemented in the mid-1990s showed some "sustained positive economic growth and improved living standards for people." This was complemented by the implementation of the "Poverty reduction Strategy Plan and the Transitional National development plan (2002-2005)" followed by the fifth

[1] http://www.who.int/gho/hiv/en/ Accessed on 26 May, 2015

[2] www.countryeconomy.com/demography life-expectancy/Zambia. Accessed on 21 February, 2015

National development plan (2006-2010) which is said to have arisen "from the need to institute a strategy that would focus on "broad-based wealth and job creation through citizenry participation and technological advancement" as the "strategy was based on rising economic growth amidst high poverty levels." (MoFNP, 2006 in ZDHS 2013-14).

This was succeeded by the Sixth National Development Plan (SNDP, 2011-2015), which was partially implemented between 2011 and 2013 and has since been followed by the Revised Sixth National Development Plan (R-SNDP) for the period 2013-2016. The Ministry of Finance and planning states that the R-SNDP identifies primary growth areas, including skill development, agriculture, and infrastructural development, and focuses on enhancing the water and sanitation, education, and health sectors. (MoFNP, 2014)

Despite its economic challenges, Zambia has seen, against all odds, some fairly significant economic gains in recent years, recorded the lowest single digit inflation rate (7%) in three decades (CSO 2010)[3] and pitched an economic growth rate of 6.6% for 2010, a good edge above an earlier projection of 5.5%[4] with boosted foreign reserves at a national all time high then, of 2 billion United States dollars (BOZ 2010).[5]

[3] Central Statistical Office, Monthly bulletin, November 2010

[20]The World Bank has credited Zambia with the ability to register seven to eight percent economic growth rate on grounds that the country has various potential sectors to trigger increased economic growth (Statement by Country Coordinator Kapil Kapoor, November 2010)

[5] Bank of Zambia, 3rd Quarter 2010 Report

2.2.2 HIV Response Overview

Zambia's first reported AIDS diagnosis in 1984 was followed by a rapid rise in the proportion of people living with HIV. Although the nation has received hundreds of millions of dollars (see Section 2.2.3) from developed country governments toward HIV programmes, disaggregated prevalence rates for certain regions of the country have remained more or less stable since the nineties, as high as 25% in some urban areas (UNAIDS, 2008). However, the national prevalence rate recorded a decline from 16.8 % (ZDHS, 2002) to 14.3% (ZDHS, 2007). Latest ZDHS national data released in April 2015 show a further reduction in the prevalence rate to 13.3%. The 2013-14 ZDHS is the third in the series of Zambian surveys measuring HIV prevalence and the first to measure HIV incidence.[6]

In the preface of the Revised National Strategic Framework (R-NASF 2014-2016) the Zambian Minister of Health[7] then noted,

> Over the last two decades, Zambia has scored tremendous achievements in halting and beginning to reverse the effects of the epidemic. Current impact level statistics from the 2007 Zambia Demographic and Health Survey (ZDHS), Modes of Transmission (MOT) study, Health Management Information System (HMIS) and the Joint Mid-Term Review (JMTR) findings show that there is a decrease in the incidence rate in adults (15+ years) from 1.6% (82, 000) in 2009 to 0.8% (46, 000) in 2012. The rate of infection in children (0–14 years old) has also dropped by up to 51% by 2012. In addition, the number of health facilities dispensing ARVs in Zambia has increased from 509 in 2011 to 564 in 2012. Through these facilities, a total of 580, 118 children and adults are receiving antiretroviral therapy out of the 708, 460 people estimated to be in need of ART. This represents 81.9% coverage. (R-NASF 2014-16)

Within the premise, the Minister cautioned, "despite this progress, however, HIV and AIDS still remains a major threat to our nation." This was in view of the fact that "in 2009, it was estimated that 226 new adult infections and 25 child

[6] Zambia Demographic and Health Survey 2013-13 Preliminary Report
[7] Dr Joseph Kasonde

infections occurred each day."[8] In an effort to understand its epidemic more accurately, Zambia undertook the *2009 Modes of Transmission* (MOT) Study, which provided insights into the "potential sources of new infections and the expected incident cases projected resulting from the transmission modes."[9]

This led to the identification of the six key drivers of the HIV epidemic, namely: 1) Multiple and concurrent sexual partnerships (MCP); 2) Low condom use; 3) Low Medical male circumcision; 4) Mobile and migrant labour; 5) Under served populations and 6) Mother-to-child transmission (MTCT) of HIV. The R-NASF indicates that the "identified drivers are further compounded by additional drivers of the HIV epidemic in Zambia" such as: 1) Lack of gender equity; 2) Gender-based violence (GBV); 3) Alcohol and substance abuse; 4) Poverty and income inequalities; 6) Stigma and discrimination; 7) Cultural practices increasing infection vulnerability and 7) Human rights violations.[10]

To contextualise the HIV situation further, the R-NASF presents the figure below along with the above findings, with the indication that the model,

> depicts the results of these estimations and indicates that having sex with multiple partners and with partners who are neither spouses nor cohabiting ("casual heterosexual sex) are the main sources of new infections, accounting for 71% of infections. The model also predicts that "low risk" sex between monogamous partners leads to a considerable number of new infections (21% of all new infections in 2008).[11]

[8] Revised National Strategic Framework 2014-2016, pp II

[9] Ibid, pp 25

[10] Ibid

[11] Ibid

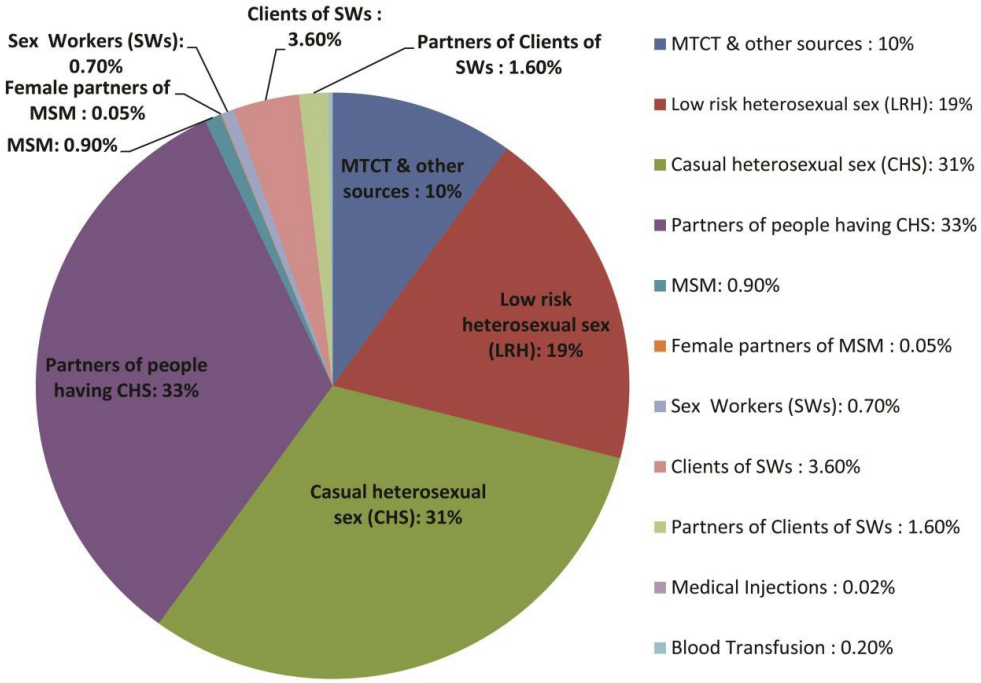

Figure 4: Sources of new infections -MOT 2009[12]

In terms of systematic response to the epidemic, Zambia commenced with the formulation of the Emergency Short-Term Plan in 1987 to ensure safe blood and blood product supplies[13] followed by the MTP1 and MTP2 being medium-term plans, covering the periods 1988-1992 and 1994-1998[14] respectively. These steps eventually culminated in the National HIV/AIDS Intervention Strategic Plan and National Monitoring and Evaluation Plan, which covered the period 2002-2005.[15]

The National HIV/AIDS/STI/TB Council (NAC) was created in December 2002 by the Zambian Parliament, and was mandated to "coordinate and support [the]

[12] Ibid

[13] ZDHS 2013-2014

[14] Ibid

[15] Ibid

development, monitoring, and evaluation of the multi-sectorial national response to HIV/AIDS, sexually transmitted infections (STIs), and TB."[16]

The ZDHS 2013-14 reports two key milestones that followed the establishment of the NAC, namely: 1) the formulation of the National HIV/AIDS Policy was established in 2005 to provide the policy direction around the mandate for the national response. Inadvertently, the policy took longer than expected to actually implement; 2) The creation of the National HIV/AIDS/STI/TB Monitoring and Evaluation Plan for 2006-2010 which was developed "to prevent, halt, and begin to reverse the spread of HIV by 2010" [17] and which currently defines the 'six themes describing priority action' areas as follows: 1) intensifying prevention; 2) expanding treatment, care, and support; 3) mitigating the socioeconomic impact of HIV/AIDS; 4) strengthening decentralised responses and mainstreaming HIV/AIDS; 5) improving monitoring of responses; and 6) integrating advocacy and coordination of multi-sectorial responses.[18]

The ZDHS 2013-14 further notes, "to facilitate effective coordination, the NAC developed the National HIV/AIDS Monitoring and Evaluation System, allowing the country to track its progress toward the plan's goals and objectives."[19] Then in 2010, the 2011-2015 National HIV and AIDS Strategic Framework (NASF) was launched with a notable emphasis on the "multi-sectorial and decentralised response" in light of the government's decentralisation plan.[20] Another distinctive of the 2011-2015 NASF was the further articulation of the following four national priorities: 1) To accelerate and intensify prevention in order to reduce annual rates of

[16] Ibid

[17] Ibid
[18] Ibid
[19] Ibid
[20] Ibid

new HIV infections; 2) To accelerate universal access to comprehensive treatment, care, and support for people living with HIV/AIDS, as well as their caregivers and families. Comprehensive treatment and care for TB, STIs, and other opportunistic infections is emphasized; 3) To mitigate the socioeconomic impact of HIV/AIDS, especially among the most vulnerable groups (such as orphans and vulnerable children, people living with HIV/AIDS, and their caregivers and families) and 4) To strengthen the capacity for a well-coordinated and sustainably managed multi-sectorial response to HIV/AIDS. (MoH/NAC, 2010).[21] The latter effort culminated in the drafting and launch of the current R-NASF 2014-2016. This has been duly aligned to all key strategic development documents.

2.2.3 HIV Funding Overview

Strategies devised by any nation in response to HIV eventually have to be taken through a costing process in light of given priorities set and a budget drafted accordingly. Zambia, like most HIV affected countries in the global south does not have sufficient local resources to its response. For instance, the cost for the implementation of current RNASF has been estimated at a "macro level using a Resource Needs Estimate" and the total funding required for a three (3) year period, is estimated at US$ 1,650,926,488. According to the NAC, the funding available in this instance is US$ 1,387,081,168, leaving a funding gap of US$ 263, 845,320.[22]

At present more than 85 % of the financial resource envelope available for the HIV response is funded from external sources that include bilateral and

[21] Ibid

[22] R-NASF 2014-16, pp 15

multilateral donors. The government of the Republic of Zambia's contribution to the health sector (which includes the HIV response) national response increased from 8.7% in 2010 to 11.3% in 2013 from locally generated revenue.

Among the international donors, the American Government's President's Emergency Plan for AIDS Relief (PEPFAR), for instance, has given Zambia a total of $1.7 billion since 2004 (NAC report 2013). The Global Fund to fight AIDS Tuberculosis and Malaria (GFATM) has to date granted Zambia US$ 1,067,196,887 out of which US$ 817,760,427 has so far been disbursed. The granted funds in this respect are currently designated as follows: HIV- US$662, 652,753; TB- US$ 44,841,353; Malaria- US$ 201,162,353; TB/HIV- US$ 153,540,427).[23]

Global Fund affairs in-country are managed through a Country Coordinating Mechanism (CCM), a multi-sectorial team of volunteers including Sector leaders like the Ministry of Health (MoH) and the NAC. In the case of Zambia, the CCM opted for a unique model of four Principal Recipients (PRs) who each specific amounts of funding for the national response. These were: 1) The Central Board of Health (CBOH) from 2003 to 2006. CBOH was later absorbed into the MoH structure on account of government restructuring of the Ministry in 2006. The MoH was then appointed the PR in 2007. However, allegations of fraudulent activities

[23] http://portfolio.theglobalfund.org/en/Country/Index/ZMB Accessed 24 May, 2015

regarding the funds eventually emerged;[24] 2) Ministry of Finance and National Planning (MoFNP) which received funds meant to be channelled to HIV activities in line ministries of the government; 3) Zambia National AIDS Network which received funds chiefly for NGOs including community based organisation; and 4) The Churches Health Association of Zambia which received funds mainly for FBOs.

Zambia has also received significant other financial as well as technical support from the governments of Great Britain, Denmark, Ireland, Sweden and the United Nations family. The figures applicable are available from the ministries of Finance, Health and the NAC as well the respective donor websites.

Many international fora in recent years have encouraged recipient governments to work strategically toward significant increments of domestic funding, particularly in the wake of the 2008 economic downturn and the shrinking global resource base. It has been emphasized that this is a sure way of ensuring sustainability particularly of the hugely expensive treatment programmes currently undertaken. That alone is a daunting task as it involves

[24] According to a filed report- *1/45 GF/B22/9-Twenty-Second Board Meeting Sofia, Bulgaria, 13-15 December 2010 (*public document) by the Office of the Investigator General of the Global Fund: "In March 2009, a suspected fraud was reported, through a whistle blower, at the MOH involving the Expanded Basket Fund and some grant funds. The allegations were related to fraudulent procurement practices. The Zambia Office of the Auditor General (OAG) carried out a forensic audit which revealed that over ZMK 36 billion [Approx. US$ 5 Million] could not be accounted for. Of this total, ZMK 1.9 billion [Approx. US$ 265,000] was related to the Global Fund grants."

so many players, including giant pharmaceutical companies in the drug supply chain.

According to Avert, in 2013, funding for the global HIV and AIDS response reached its highest ever level with an estimated $19.1 billion made available for programmes in low and middle-income countries. However, comparatively within for that year, funding from *donor governments* actually fell to $8.07 billion, a 3 percent drop on 2012.[25] Avert pointed out that this drop was "primarily the result of declining annual commitments by the United States government - the world's largest HIV donor, adding, "disbursements (resources made available to the field) increased by 8 percent to $8.46 billion." These are huge resources and they still do not meet the full need or gap of respective national responses. Understanding that ARV treatment, for instance, once commenced by some one, is a life long commitment. One might ask: what steps must recipient governments take to ensure sustainability of the life saving drugs currently secured through the generosity of donor countries?

The R-NASF indicate has indicated that "one of the key options for increasing the finances available to the health sector through sustainable means has been identified as the establishment of the Social Health Insurance Scheme."[26] Further, the R-NASF explains,

> The National Social Health Insurance Scheme shall, among other functions, supplement the normal funding mechanism to the health sector in general and the National HIV response in particular. This will, therefore, increase sustained funding to the sector which is a necessary step towards achieving universal health coverage and provision of access to quality health care. Other options for increasing financing for health include the integration of HIV programming in all capital projects through the Environmental and Social Impact Assessment.[27]

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[25] http://www.avert.org/funding-hiv-and-aids.htm#sthash.j2ulNfOb.dpuf Accessed 24 May, 2015

[26] Ibid

[27] Ibid

The matter of funding the HIV response is weighty and will need careful handling by current donors and recipients. Apart from the almost obviously observable challenge of 'dependency' occasioned by donor funding, there are complex compliance matters that go beyond the required standard transparency and accountability in the use of committed financial resources. Some recipient governments have been concerned about conditionality and priority targets that are actually set by the donor yet may be at variance with national targets and priorities.

While cases related to the latter respect are real, a 'caveat' must be indicated to the effect that for certain bilateral or multilateral funding arrangements, there is normally a shared framework that commences from activity planning stages, all the way to budgeting and mutual agreement on 'bottom line' funding limits between donor and recipient, way before commitment of specific funds and disbursement of the same. These cases represent important exceptions where a reasonable level of mutually consultative planning has resulted in well-executed programmes on the ground. For example, Zambia and the US government, particularly through PEPFAR have collaborated in key thematic areas of the national response and the USG has stated the following in one of its partnership documents:

> The United States is supporting Zambia as it takes the leadership role in its fight against HIV/AIDS. In November 2010, the Governments of Zambia and the United States signed a Partnership Framework on HIV/AIDS, which outlines a five-year joint strategic plan to build a country-led, sustainable response.[28]

[28] http://www.pepfar.gov/documents/organization/199573.pdf Accessed 24 May, 2015

PEPFAR funding has, over the years, played an important role in building the capacity of FBOs including congregations to engage more effectively in the national response.

On a different note, some donor conditionality attached to financial assistance has arisen out of instances of misapplication of funds as well as blatant corruption, vices that are abhorred by both donors and recipient governments.

Looking ahead, recipient governments have to plan for the near future and work towards greater ownership of the HIV response and seek eventually to grow the domestic resource envelope. The ideal situation would be one where donor funding simply comes to supplement locally raised funds. In the mean time, global collaboration with external funders must still be harnessed alongside careful management of emerging challenges.

2.3 RELEVANCE OF THE STUDY

As is the case in most HIV affected countries in Sub-Saharan Africa, Zambia's situation, despite visible economic resurgence, is undoubtedly still aggravated by many other factors including poverty, which deals a devastating impact on the basic fabric of its society. It is mostly people in the parent and teacher age group who, for many years, have been falling sick and dying - leaving thousands of orphans and vulnerable children, and potentially crippling the education system.

That is why it is vital to engage rigorous research at various societal levels in order to understand better the dynamism of HIV and seek to expand efforts or interventions that can be ascertained as yielding most impactful life saving results on the suffering population. Evidence is gradually emerging that faith-based HIV

interventions such as abstinence and particularly marital fidelity, largely carried through church congregations may be producing such impact, but to what extent?

The World Health Organisation (WHO) admits that abstinence and marital fidelity may constitute strategies capable of completely eliminating the risk of infection from HIV and other sexually transmitted diseases (STDs) while condoms, on the other hand, reduce the risk of infection (WHO, OMS 1992). Research data show that abstinence and reduction in the number of sexual partners were the most important behavioural changes linked to HIV prevalence decline in Uganda (Asiimwe *et al.* 1999).

More accurately, Green and Ruark (2006) pointed particularly to the 'B' factor as what really was the 'game changer' in the ABCs of the Uganda success story. They reported, "data show that compared to other countries in Africa, it was with regard to B behaviors that Uganda was different." [29] They specifically explicated,

> Condom use was not higher in Uganda than in other countries. Rather it is differences in "Be faithful" behaviors that Uganda stands out. There was far less multi-partner sex in Uganda than in other countries.[30]

In Zambia, as in much of Africa, church congregations are important units of social identity. "Be faithful" messages have fertile ground in congregations due to the spiritual norms found in the Scriptures, which are already part of marital rites in church congregations. Zambia stands to gain significantly from the efforts of the thousands of church congregations owing to their constructive social engagement in general and their increased involvement in the fight against HIV in particular. The

[29] Green, Edward, C and Ruark, Allison, H 2006, 'Paradigm Shift and Controversy in AIDS Prevention' *Journal of Medicine and The Person*, Vol. 4 no 1, pp. 23-33

[30] Ibid

growing efforts of church congregations will help the people to adopt safer behaviour patterns as they attain better levels of knowledge regarding causes of the disease. This will result in implementation of more effective preventive measures that will assist to reverse the devastating impact of the AIDS pandemic.

Bearing a comparative advantage of captive weekly gatherings and dedicated ministry allocations such as men's groups, women's groups, youth ministry teams, and so forth that serve as peer-to-peer interactive fora, church congregations in Zambia have, for many years, catalysed direct compassion initiatives in various communities. These are groupings where individuals care for one other as a matter of routine courtesy that is part and parcel of their livelihood. Thus, to care for a fellow brother and/or sister is not a new task. It is the natural course of life and inevitable moral duty or responsibility to meet each other's needs in tangible ways. These virtues necessarily manifest at institutional levels as well.

For instance, positive engagements by the Christian faith community in healthcare provision as benevolent steps towards meeting human needs in society, though not documented largely, date back to the early 1800s. It is therefore an error to see the church as espousing social action more or less in incidental fashion. Rather, the church, since time immemorial, has been instrumental in responding to human need holistically. This is a substantive historic engagement that essentially pre-dates the visible establishment of health institutions.

These actions therefore are motivated by a sense of mission and mandate derived from the Christian scriptures. That is the essence of the "good news" announced by the Lord Jesus Christ in the gospel record of Luke 4:18:

> The Spirit of the Lord is on me, because he has anointed me to preach good news to the poor. He has sent me to proclaim freedom for the prisoners and recovery sight for

the blind, to release the oppressed, to proclaim the year of the Lord's favour.[31] (NIV Bible 1984)

2.4 PROBLEM STATEMENT AND JUSTIFICATION FOR THE STUDY

Even though Zambia's national prevalence rate of HIV has dropped to 14.3%,[32] the negative impact on the health of its citizens and indeed that of many African countries and the resultant policy crisis calls for in-depth study. Despite the many educational programmes and public awareness campaigns, some significant sections of the Zambian society are still not aware sufficiently of the disease and the preventive measures.

The 2007 Country Report to the United Nations General Assembly (UNGASS: indicator number 13) revealed that only 50.7 % of young people aged 15-24 were able to identify correctly, both ways of preventing the sexual transmission of HIV and rejecting major misconceptions about HIV transmission (UNGASS Zambia Country Report, 2006-2007). The spread of knowledge and awareness of HIV across the disaggregated population groups in this case showed that young males were more knowledgeable at 52.3% while females of the same age group scored 49.4% (ZDHS, 2007).

Though there have been many studies (Wenhardt, *et al.* 1999; Falley; *et al*. 2007) the effects of the disease, reviewers and reviewees, there is now a growing interest in assessing the development of the people's attitudes to increase their awareness. More recently, the situation among young people's low levels of

[31] Holy Bible, New International Version®, NIV® Copyright © 1973, 1978, 1984, 2011 by Biblica, Inc.® Used by permission

[32] 2007 Zambia Demographic and Health Survey

knowledge and awareness of HIV has necessarily drawn much attention in HIV programming.

Given the personally observed and encountered progression of the HIV pandemic, the UNGASS indicator noted above and indeed the call for a robust multi-sectorial national response (NAC, report, 2007), there is need for in-depth research to explore more effective ways of stemming the tide of new HIV infections. In particular, the need to learn from inherent potential of church congregations and perhaps to utilise the largely untapped potential of behaviour-based HIV responses such as abstinence and marital fidelity (A & B of the ABC approach). The value base therein arguably forms a huge comparative advantage for church congregations, given their wide reach in most parts of Zambia and the massive human, infrastructural and moral resource. Some evidence available points to the latent potential of religious services in general and congregational response in particular.

A study, led by David C. Atkins and Deborah E. Kessel of the Fuller Theological Seminary, has revealed that attendance at religious services predicts marital fidelity. The study, in which participants were drawn from the 1998 General Social Survey (GSS) conducted by the National Opinion Research Centre, explores how various dimensions of religious life, including prayer, closeness to God, faith, and religious activities related to fidelity.

In the study, researchers found that religious service attendance was the only unique, religious predictor of fidelity while prayer, importance of religiousness, and strong reported faith were not predictors. According to researchers, attendance likely implies prevention of infidelity in the sense that it is a shared activity between spouses. They believe that attending services can create a strong network of relationships within the church, synagogue, or mosque that can provide social

support to the spouses. Besides this, they feel that attending services means that an individual is hearing religious teaching on marital fidelity and the general importance of marriage.

Sexual abstinence is a choice to refrain from sexual activity. This choice is usually made for a specific reason. The reason may be moral, religious, legal, or for health and safety. The choices of what is acceptable may depend on the purpose of the abstinence. The choice of abstinence may be based on moral or ethical reasons that sexual expression should be reserved as an expression of a lifetime commitment to one person. This has direct impact one's motivation/decision to avoid pregnancy or to avoid any sexually transmitted infections.

Trinitapoli and Regneras (1998-2001) examined the role of religion in influencing men's attitudes and behaviour in relation to HIV risk. They established that attendance at religious services is an important factor in predicting HIV risk behaviours and perceived HIV risk. However, their study noted that religious denomination is less of a deciding factor.[33] Through a qualitative ethnographic study, Trinitapoli (2004) explored how churches respond to the AIDS crisis. Results from the interviewing established religious leaders were found to discuss HIV and related issues and congregations were found to respond to AIDS-related issues through home base care, sponsoring education for AIDS-affected youths and encouraging orphan care and support.[34] The trends, potentials and inferable implications require further exploration.

Since the remarkable story of Uganda's rapid decline of both prevalence of HIV in the general population and the eventual drastic reduction in incidence of new

[33] Campbell, *et al*.

[34] Ibid

infections and the finding that A and B (and more the B, Green and Ruark 2006), A & B have become rather controverted. The risk of neglecting these two preventive options could be imminent (2007). Also, the opportunity to learn from FBOs generally and church congregations in particular, some of who are doing significant, howbeit, unmeasured HIV response work (Nussbaum 2005) could become a missed opportunity. Grills' (2007) citing of the works of Kniss and Campbell, 1997 and Birdsall 2005, as seeking to positively "characterise the faith-effect on African FBOs"[35] may serve as an important pointer.

Bob Roehr (2005) argued that the "use of condoms and death explain the substantial decline in the prevalence of HIV in Uganda in the past decade."[36] This result, which was released at the 12th retroviral conference, was based on a longitudinal study that included "a door to door survey of about 10,000 adults aged 15-49 in 44 villages in the Rakai district of southern Uganda,"[37] challenging the reduction that had "previously been credited to ABC programme"[38] and in particular the "contributions of abstinence and fidelity."[39]

However, Green *et al*. (2006) posited findings to the effect that, it was:

> Behavio[u]r change programs, particularly involving extensive promotion of "zero grazing" (faithfulness and partner reduction), largely developed by the Ugandan government and local NGOs including faith-based, women's, people-living-with-AIDS and other community-based groups, contributed to the early declines in casual/multiple sexual partnerships and HIV incidence and, along with other factors including condom use, to the subsequent sharp decline in HIV prevalence. Yet the debate over "what happened in Uganda" continues, often involving divisive

[35] Grills, Nathan, DPhil Thesis, St. John's College, University of Oxford

[36] Roehr, B. (2005). Abstinence programmes do not reduce HIV prevalence in Uganda. *BMJ : British Medical Journal*, *330*(7490), 496.

[37] Ibid

[38] Ibid

[39] Ibid

> abstinence-versus-condoms rhetoric, which appears more related to the culture wars in the USA than to African social reality.[40]

Against the background above, this study set out to find out whether, how and to what extent congregation-based, faith-based outreach efforts to HIV+ persons in the community aimed at promoting marital fidelity and abstinence can alter their well-being, life-prospects, knowledge and attitudes about HIV and, in particular, reduce risky behaviour and further transmission of the virus.

2.5 OBJECTIVES OF THE STUDY

Two objectives for the Study were established:

1. To assess how interventions effect impacts in congregation-based HIV programmes, and
2. To learn how abstinence and marital fidelity function within the larger picture of overall strategies to combat AIDS.

The community outreach work of the Circle of Hope Family Care Centre, a congregation-based HIV/AIDS support group initiative undertaken by the Northmead Assembly of God Church in Lusaka, Zambia was selected as the focal point location for the key interventional activities also to enable eventual evaluation of the magnitude of its impact.

The main research question guiding the study was: Is a person's sexual behaviour influenced by their attitude and behaviour towards God? The 2 subsidiary questions were:

[40] Green, E. C., Halperin, D. T., Nantulya, V., & Hogle, J. A. (2006). Uganda's HIV Prevention Success: The Role of Sexual Behavior Change and the National Response. *AIDS and Behavior*, *10*(4), 335–346. doi:10.1007/s10461-006-9073-y

1. What are the factors, which affect a person's sexual lifestyle?
2. Does attendance at the church's HIV/AIDS programmes cause a change of behaviour in a person's sexual relationships?

The working hypothesis for the study was that "***a person's sexual behaviour is influenced by their attitude and behaviour towards God. Further, in the context of this study, the intervention [here designed] makes a difference to the sexual behaviour of those undergoing it'.***

In terms of process, the study set out to create awareness about HIV and the ways to reduce the risk of such transmission of the virus. With the help of congregation-based and faith-based efforts, particularly the attendance of a church programme with spiritual content convened through COH, the attitudes of the people were surveyed and the applicable preventive measures and spiritual truths were taught to them.

Congregation-based efforts on a full range of community interactions involved in HIV were identified and targeted to collect information on the HIV+ persons and those affected. With the help of their responses, the effects of abstinence and marital fidelity were taught and surveyed and the overall impacts of such efforts and strategies were found out.

The study then determined how interventions affect impact in congregation-based HIV interventions. The study also identified some causal factors responsible for increased impact of congregation-based HIV interventions and the magnitude of impact for COH interventions in particular was evaluated.

2.6 APPROACH TO THE STUDY

To address the objectives of this study, a quasi-experimental research design was used. This is because the quasi-experimental design enabled the comparison of a treatment and control group with one another to determine whether there were significant differences between the two groups.

The quasi-experimental design utilised interviewing and coding to provide before and after measures for a treatment cohort and a control group. This allowed for quantitative and qualitative analysis of responses. Yet the Circle of Hope programme as a whole was treated as a focal point of the intervention in the study as a location actualising congregation-based and faith-based approaches, combining palliative care and efforts to reduce transmission through altering risky behaviour.
The researcher sought to determine whether there was a significant difference between the treatment cohort and the control group when it comes to those abstinent before marriage, being maritally faithful, in terms of lifestyle and other dependent variables.

Thus the study compared a cohort of non-residential HIV+ patients currently on treatment at COH with a Control cohort of non-patients (affected by HIV) and purposively selected within the Makeni community. Both groups were interviewed to provide a baseline and again after 3 months (See Chapter 3- Methodology and Chapter 4- Intervention and its Content)

2.7 SUMMARY OF CHAPTER 2

This chapter, which has provided a general picture of the HIV situation globally and nationally for Zambia, highlighted the economic outlook, the response,

along with the challenges and nuances of funding within the national context. It has also introduced the relevance, the problem statement, the objectives and approach of the study. It argues that despite a slight decline recorded in the general prevalence rate of HIV in Zambia, 13.3 % is still unacceptably high, dealing devastatingly upon the Zambian people and necessitating an in-depth study to trigger more drastic and strategic policy measures. The chapter also notes the low levels of HIV awareness among young people aged 15-24 which raises grave concern. Church congregations are well placed to help the people understand the causes and effects of the disease.

It further explicates why promoting marital fidelity and abstinence to HIV+ persons in the community, with the help of congregation-based and faith-based outreach efforts may be able to increase significantly the awareness levels of the dangers of HIV.

The chapter underscores that the study investigated whether this awareness helps people to alter their well being, life prospects, knowledge and attitudes about HIV and, in particular, reduces risky behaviour and further transmission of the virus.

CHAPTER 3: REVIEW OF LITERATURE

The review of literature looks at the results of a search of the current literature regarding HIV/AIDS and several methods of combating the pandemic. The following literature review was conducted by using keyword searches in library catalogue systems, online journal databases, online journal database search engines, and online search engines.

3.1 ZAMBIA AND HIV/AIDS

Zambia is a country slightly larger than the state of Texas in land area, located in south-central Africa (CIA World Fact book, 2009). Estimates of any country's population often take into account the country's excess mortality rate thought to be caused by AIDS. Higher rates of AIDS, like those present in Zambia, can cause lower life expectancies, higher infant mortalities, higher death rates, lower population growth rates, and changes in the population distribution by age and sex. For example, only 2.4% of Zambia's population is over the age of 65. Furthermore, about 45% of the population is of age 14 or younger and 52% are between the ages of 15 and 64 (CIA World Fact book).

Zambia is ranked seventh among sub-Saharan Africa countries faced with a heavy burden of HIV. [1] At the said current national prevalence rate of 13.3%, Zambia has what may now be considered a mature, generalised HIV epidemic

[1] NAC Reports, 2011

largely fuelled by a combination of behavioural and structural factors, gender and social norms as well as unequal distribution of wealth and access to employment.[2]

Despite the challenges posed by the epidemic, Zambia has managed to turn the tide and score many successes in responding to HIV. Guided by successive National AIDS Strategic Frameworks (NASF) since the establishment of the National AIDS Council, Zambia has recorded significant achievements in service delivery, resulting in 70% of people who are eligible for antiretroviral therapy (ART) receiving treatment and 61% of pregnant women accessing prevention of mother to child transmission (PMTCT) of HIV.[3]

Notwithstanding the cited gains, the National AIDS Council (NAC) of Zambia stated correctly that following "the human toll of AIDS" there is "no aspect of life ... [that] has not directly or indirectly" suffered (NAC Report, 2003). HIV impacts gravely on development as well as health in many African countries. The resultant policy crisis calls for in-depth study and research to inform appropriate strategic responses.

A congregation-based study allows investigation of a full range of community interactions involving HIV/AIDS, in a controlled and delimited setting that permits thorough investigation.

Zambian churches have responded to societal concerns with innovative community interventions. The churches were initially silent about HIV/AIDS, but as many parishioners were affected, church congregations began to act. At first, AIDS was viewed simply as a health problem, reflecting a standard bio-medical approach. Church response was then confined to church-owned professional institutions such as

[2] Ibid

[3] NAC Reports 2011

hospitals and schools. The Churches Health Association of Zambia (CHAZ) spearheaded the interventions through its network of hospitals. Yet many observed that, to be adequate, church response required actual involvement by church congregations. Congregation-based initiatives have since spread as models of learning, generating significant societal transformation. However, these initiatives have not been studied sufficiently to ascertain correlations and/or causal factors at play.

3.2 HIV INTERVENTIONS

In Zambia, and in Africa generally, HIV is the largest contributing factor of the disease burden (Creese, Floyd, Alban, & Guinness, 2002). Governments in these countries must decide how properly to allocate funds to the prevention, treatment, and care of HIV/AIDS in order optimally to address the HIV/AIDS epidemic. Creese *et al.* examined over 60 reports that measured the cost and effectiveness of HIV/AIDS interventions across Africa.

Of these, the authors examined 24 studies more thoroughly in order to determine further which interventions were most logical. Creese *et al.* examined the following from each of the 24 studies: definition of intervention, countries of intervention, questions addressed, year of evaluation, year of prices, discount rate, what costs were included, whether all important costs were included or if only a limited number were, if standard costing methods were used, the outcome measures used, the transparency of the assumptions, the main assumptions, the target group, risk group, and general population, the type of study, if sensitivity analysis was conducted, which assumptions were tested, and the main results of each.

Six different intervention groups for prevention were determined and tested for cost effectiveness, including condom distribution, blood safety, peer education for prostitutes, prevention of mother-to-child transmission, diagnosis and treatment of STDs, and voluntary counselling and testing. Table 4 displays each of the interventions along with vital information regarding the studies examining each, and the effectiveness and cost of each. Similarly, five intervention groups for treatment and care were studied and are displayed in Table 5, including, short-course treatment for new sputum-smear positive tuberculosis patients, co-trimoxazole prophylaxis for HIV-positive tuberculosis patients, home-based care for people with AIDS, preventive therapy for tuberculosis, and antiretroviral therapy for adults.

Table 4: Unit costs and estimated effects for HIV/AIDS interventions for prevention. Adapted from Creese, et al. (2002). Cost-effectiveness of HIV/AIDS interventions in Africa: A systematic review of the evidence. The Lancet, 359, p. 1638.

	Place and year of publication	HIV prevalence	Unit cost, year 2000 prices (US$)	Unit	Effectiveness, HIV infections averted per unit	Effectiveness, DALYs gained per unit*
1. Condom distribution						
Condom distribution plus STD treatment for prostitutes	Sub-Saharan Africa, 1991[22]	Prostitutes: 80% Clients: 90%	217·76 0·18	Per prostitute reached Per contact	12·8–19·25	283·5–425·2
Female condoms targeted to:						
prostitutes	Kenya, 1999†	F: 55% M: 14%	237·38		0·86	19·10
high-risk women	Kenya, 1999†	F: 28% M: 14%	5·33	Per woman	0·005	0·11
medium-risk women	Kenya, 1999†	F: 15% M: 14%	5·47		0·002	0·06
2. Blood safety						
Strengthening blood transfusion services through:						
Rapid test	Zimbabwe, 1995[21]	19%	11·5	Unit of blood transfused	0·187	4·14
Test and defer high-risk donors	Zimbabwe, 1995[21]		9·1–14·3		0·189–0·193	4·13–4·27
Defer high-risk donors	Zimbabwe, 1995[21]		0·42–8·6		0·023–0·081	0·52–1·78
Hospital-based screening	Zambia, 1995[18]	16%	15·0	Usable unit of blood	0·140	3·1
Hospital-based screening	Tanzania, 1999[33]	12%	1·3	Usable unit of blood	0·071	1·6
Improved blood collection and transfusion safety, excluding screening	Tanzania, 1999[33]	12%	14·7	Usable unit of blood	0·015	0·3
Improved transfusion safety with outreach	Zimbabwe, 2000‡	Donors: 7% Recipients: Adults: 25–50% Children: 5–9%	33·31	Usable unit of blood	0·13–0·16	2·9–3·5
3. Peer education for prostitutes	Cameroon, 1998§	21%	60·84	Per prostitute covered per year	0·38–0·77	8·32–17·01
4. Prevention of mother-to-child transmission						
Single-dose nevirapine (universal coverage)	Uganda, 1999[20]	5–30%	85 999	Per 20 000 women treated	603	17 607
Single-dose nevirapine (targeted coverage)			146 463		476	13 899
Single-dose nevirapine (universal coverage)	Sub-Saharan Africa, 2000[32]	5–30%	42 891	Per 10 000 pregnant women	160	4672
Single-dose nevirapine (targeted coverage)			1750–48 455		89–142	467–4146
Zidovudine/CDC Thai regimen	South Africa, 2000[27]	6–27%	187–330	Per HIV-positive pregnant woman treated	0·15–0·20	4·4–5·8
Zidovudine/CDC Thai regimen	South Africa, 1999[25]		377 095		160	4672
Petra regimen	South Africa, 1999[25]		33 279	Per 20 000 women	124	3621
Formula recommendation	South Africa, 1999[25]		99 684		26	759
Formula provision	South Africa, 1999[25]	0·1–40%	125 138		25	730
Breast feeding 3 months	South Africa, 1999[25]		106 777		5	146
Breast feeding 6 months	South Africa, 1999[25]		235 130		37	1080
5. Diagnosis and treatment of STDs	Tanzania, 1997[19]	4%	12·66	Per client	0·047	1·03
6. Voluntary counselling and testing¶	Kenya, 2000[26] Tanzania, 2000[26]	20% 20%	28·76 30·89	Per client per year Per client per year	0·073 0·068	1·6 1·5

F=female. M=male. STD=sexually transmitted disease. *Rounding errors mean that DALYs gained per infection averted (column 7 divided by column 6) do not always appear consistent; †Homan RK, Visness C, Welsh M, Schwingl P, personal communication; ‡Watts C, Goodman H, Kumaranayake L, personal communication; §Kumaranayake L, Mangtani P, Boupda-Kuate A, et al, personal communication; ¶voluntary counselling and testing is considered in the literature as an intervention related to both prevention and care. However we have classified it as a prevention activity in accordance with the study.

Table 5: Unit costs and estimated effects for HIV/AIDS interventions for treatment and care. Adapted from Creese, *et al*. (2002). Cost-effectiveness of HIV/AIDS interventions in Africa: A systematic review of the evidence. *The Lancet*, 359, p. 1639

	Place and year of publication (reference)	HIV prevalence (%)	Unit cost, 2000 prices (US$)	Unit	Effectiveness, DALYs gained per unit
1. Short-course treatment for new sputum-smear positive tuberculosis patients					
Ambulatory care	Malawi, Mozambique, Tanzania, 1991[24,31]	HIV prevalence among tuberculosis patients not quoted in original studies. Assumed to vary from 30–75% in standardised analysis	101–129	Per patient treated (applies to all studies)	37–61
	Uganda, 1995[29]		113		32–47
	South Africa, 1997[17]		485		31–60
IUATLD model (involves 2 months' stay at hospital at treatment outset followed by monthly visits to a health clinic to collect drugs during the remainder of treatment)	Malawi, Mozambique, Tanzania, 1991[24,31]		226–306		37–61
	Uganda, 1995[29]		134		32–47
	South Africa, 1997[17]		2078		31–60
Community-based directly observed treatment	South Africa, 1997[17]		760		36–55
2. Co-trimoxazole prophylaxis for HIV-positive tuberculosis patients	Hypothetical low income country*	Not relevant to analysis	14·76	Person year of treatment	2·5
3. Home-based care for people with AIDS					
Community-based programme	Zambia, 1994[16]	Not relevant to analyses	49	Person year of care	0·495
	Tanzania, 2000[23]		38		
Health-facility-based programme	Zambia, 1994[16]		337		
	Tanzania, 2000[23]		389		
	Zimbabwe, 1998[30]		232 (urban) 609 (rural)		
4. Preventive therapy for tuberculosis					
Isoniazid, 6 months	Uganda, 1999[15]	Not stated	25	Person treated	0·15
Isoniazid plus rifampicin, 3 months	Uganda, 1999[15]		40		0·14
Rifampicin plus pyrazinamide, 2 months	Uganda, 1999[15]		48		0·17
5. Antiretroviral therapy for adults	Senegal and Côte d'Ivoire, 2000	11% Cote d'Ivoire	1100	Person year of treatment	1
	South Africa, 2000[13]	12–16% South Africa	350	Person year of treatment, 25% of HIV-positive adults	5–7 life years gained

IUATLD=International Union Against Tuberculosis and Lung Disease. *Guinness L, personal communication.

The results of the research by Creese *et al.* (2002) showed that there is considerable variability with regard to the cost-effectiveness of the several interventions. Interventions aimed at the prevention of HIV/AIDS and the treatments of tuberculosis were the most cost-effective. Alternatively, Highly Active Antiretroviral Therapy (HAART) for adults and home-based care organisations were found to be least cost-effective. Different methods of intervention between each of the intervention groups were found to differ in terms of cost-effectiveness. Creese *et al.* mentioned that although cost-effectiveness is important, several other factors, such as appropriateness and feasibility, should be considered when making decisions regarding interventions are made. However, with the current state of Africa,

particularly its relatively scarce financial resources, the cost and effectiveness of HIV/AIDS interventions are important considerations. Table 6 (below) summarises the results of the study.

Table 6: Summary of Cost-Effectiveness Results from Creese *et al*. (2002)

	Public Good?	Important Externalities	Adequate Demand	Catastrophic Cost	Voluntary Insurance available for catastrophic cost?	Benefit group poor?	Cost-effective? (US$ cost per DALY)
Condom distribution	No	Yes	No	No	N/A	Yes	1-90
Blood safety	No	Yes	Yes	No	N/A	Yes	1-43
Peer education for prostitutes	No	Yes	No	No	N/A	Yes	4-7
MCTC	No	No	?	No	N/A	Yes	1-731
STDs	No	Yes	No	No	N/A	Yes	12
VCT	No	Yes?	No	No	N/A	Yes	18-22
TB short course	No	Yes	Yes	Yes	N/A	Yes	2-68
Co-trimoxazole prophylaxis	No	No	?	No	N/A	Yes	6
Home care	No	No	?	Yes	No	Yes	77-1230
TB preventive therapy	No	Yes	No	?	No	Yes	169-288
ARV therapy	No	?	Yes	Yes	No	Yes	1100-1800

Sikkema *et al.* studied the effects of HIV/AIDS interventions for prevention in low-income, housing development communities in five cities in the United States. The housing developments were situated in areas with high rates of poverty, sexually transmitted diseases, and drug use. Participants in the study underwent assigned interventions, either the control intervention, a workshop intervention, or community-level intervention. The control intervention was an AIDS education session, and condoms and educational brochures were made available. Workshop intervention included two three-hour workshops on topics such as HIV and STD education, skills training to avoid and resist unwanted sexual activity, sexual negotiation skills, condom use skills, and risk behaviour self management. The workshops also stressed personal pride and self-respect.

The following three aspects of risk avoidance were the focus of these workshops: (1) delaying the onset of sexual activity, (2) refraining from unwanted sex among those sexually active, and (3) consistently using condoms if one was, or became, sexually active. Community-level intervention included the workshop intervention in conjunction with a multi-component community intervention. The multi-component intervention included: (1) follow-up sessions, (2) participation of opinion leaders in a Teen Health Project Leadership Council (THPLC), (3) THPLC sponsored activities to create social and environmental supports for HIV risk avoidance, and (4) HIV/AIDS workshops for parents. Interventions were found to be positively correlated with participants remaining abstinent and with participants' condom use.

The research by Sikkema *et al.* indicated that community-level HIV/AIDS prevention interventions offer the opportunity to provide a social context in which risk-reduction efforts can be supported and maintained, thus resulting in fewer cases

of HIV/AIDS. The research supports the use of community-level interventions as effective in reducing the risk for HIV/AIDS among vulnerable adolescents and young adults.

Pearlman, Camberg, Wallace, Symons, and Finison (2002) studied the effects of a community-based HIV/AIDS peer leadership prevention programme on newly enrolled peer leaders and youth enrolled as peer educators. The intervention consisted of a short course to plan and implement HIV/AIDS outreach activities to youths. Data collected included demographic and sexual history data, knowledge of HIV/AIDS, knowledge of planning and presenting skills, self-efficacy measures, perception of self as a change agent, sexual-risk taking behaviour, and perceptions of the Protect Teen Health programme. Results indicated that peer leadership could be an effective and efficient strategy for increasing adolescents' knowledge level of HIV/AIDS. It was determined that after nine months, those enrolled, as peer leaders were more knowledgeable regarding HIV/AIDS. Such programmes also made participants more confident.

Gordon, Forsyth, Stall, and Cheever (2002) studied methods to help those living with HIV to adopt and sustain HIV/AIDS and other STD risk reduction, treatment adherence, and other effective strategies for coping with HIV/AIDS. Their research suggested that interventions are needed by community organisations and clinics.

Gordon *et al.* provided an overview of various studies that involved interventions with those who have HIV/AIDS. Table 7 shows a summary of the studies examined by Gordon *et al.*

Table 7: Summary of Studies in Gordon *et al*. (2002)

Author and trial status	Sample and requirement	Intervention description	Primary findings	Target population and setting
1. Kalichman et al. (2001) Published	N-332 (men =233 women = 99.74% African American) recruited from AIDS service organizations and clinics in Atlanta	Five 120 minute sessions for Intervention (HIV skills, emphasizing disclosure and healthy relationships) and comparison condition (Other health issues, HIV treatment adherence)	At 6-month assessment, less un-protected sex, fewer HIV seronegative partners and more occasions protected by condoms use in intervention group versus comparison	MSM, heterosexual and bisexually identified men and women at CBO
2. Rotherm-borus (2001) Published	N-310 (27% African Americans, 37% Latinos) Adolescents recruited from community agencies in 4 sites: New York City, Los Angeles, Miami and San Francisco	Three modules of small groups 23 sessions focused on (a) "staying healthy"- where medical care skills practiced (b) "Act safe"- stopping drug use, increasing safer sex, (c) "being together" –Mental health issues, quality of life, anticipated relapse.	At 21-month follow up assessment, intervention participants reported 82% fewer unprotected sexual acts, 45% fewer sexual partners and 50% fewer HIV Negative sexual partners compared with those in the delayed condition.	Primarily gay/bisexual young men,/heterosexual/young women at CBOs
3. Margolin (2003) Published	Participants(N=90: 70 % men, 49% African American, 16% Hispanic) IDU's entering a methadone maintenance programme in New Haven, CT.	Compared twice weekly group therapy in conjunction with an enhanced methadone maintenance programme to standard maintenance, plus 6-session HIV risk reduction	Patients assigned to the more intensive intervention were less likely to have engaged in high risk sexual behavior at 9- month follow up	IDU's in methadone maintenance programme
4. Patterson et al. (2003) Published	N=387 (91% male, 85% homosexual) recruited from HIV clinics, social services, and communities around the San Diego .	Randomized to one of two brief (60-90 minute; targeted Vs. comprehensive) sessions with or without boosters sessions, compared with attention control exercise conditions	All four conditions (including exercise comparison condition) resulted in a decrease in total unprotected occasions over 12 months.	MSM, mixed recruitment settings
5. Richardson et al. (2004) Published	N=585 (85% men, 74% homosexual) recruited from 6 primary care HIV clinics in CA	HIV clinics randomly assigned to condition: (a) gain from safer sex; (b) loss from safer sex; (c) adherence (attention control). Brief intervention messages (3-5 min) delivered at every clinic visit for study period.	For loss-frame participants with ≥ 2 partners at baseline, 30% reduction in unprotected intercourse. No effects for those with with 1 partner at baseline. No effects in gain frame condition.	Primarily MSM, heterosexual women in HIV treatment clinics

6. Wingood et al. (2004) Published	N=366 (Women (84% African American) recruited from AIDS service organizations, health departments and community based agencies in AL and GA.	Four weekly sessions (4 hours each) co-facilitated by health educator and HIV positive female peer. Focused on (a) gender pride, goal setting, values; (b) emotion-focused coping; (c) assertive communication and (d) condoms use. Compared with time-matched intervention .	Of the women in the WILLOW and comparison interventions, 95 % and 98 % completed all four sessions. Retention for both conditions at 6- and 12-month follow-up ranged from 85% to 93%.	Primarily heterosexual African American women recruited from CBOs and health departments
7. Fisher et al. (2004) Formative, feasibility and fidelity data. Published: Primary outcome proper under review	N=231 patients (53% male, 52% African American,17% Latino/a, 27% Caucasian,79% heterosexual) at Intervention clinic. Control clinic offers standard of care.	All clinicians at intervention clinic conduct intervention at appointments to set agenda, assess risk, solicit ratings of importance (motivation) and confidence (self-efficacy) to change risk behavior, and prescribe a prevention plan.	Of 1,455 medical visits for intervention patients, 73% received the intervention. With repeated exposure to intervention over subsequent visits, 6 % of total sample failed to receive any intervention during the trial.	Primarily heterosexual minority men and women at HIV treatment clinics

Source: Gordon *et al*. (2002). Prevention interventions with persons living with HIV/AIDS: State of the science and future directions. AIDS Education and Prevention, 17, pp. 8-9.

Kalichman *et al.* (2005) studied the effects of HIV/AIDS risk-reduction counselling on patients already receiving clinic services for sexually transmitted infections. Data was collected regarding the following categories: demographic characteristics, information—HIV/AIDS knowledge, motivation—HIV prevention behavioural intentions, behavioural skills—self-efficacy for condom use and skills enactments, sexual behaviour outcomes, sexually transmitted infections, and counsellor rating scales. Intervention sessions reviewed three components: information/education, motivational enhancement, and behavioural self-management and sexual communication skills.

The results of the study supported the use of risk-reduction counselling and indicated that even brief counselling may have positive effects on sexual risk behaviours in those who receive sexually transmitted infection diagnostic and treatment services. The counselling influenced participants to reduce both sexual risk behaviour and rates of unprotected intercourse.

3.3 General HIV Prevention

Advert, an international AIDS charity, pointed out that HIV is transmitted in only three ways: through sexual transmission, transmission through blood, and mother-to-child transmission. With regard to sexual transmission, both Advert and the United States Centres for Disease Control (CDC) advocate following the three ABCs of HIV prevention:

- Abstain from sex or delay first sex
- Be faithful to one partner or have a reduced number of partners
- Condomise, or use male or female condoms consistently and correctly

Given the progress made in expanding treatment initiatives globally, it is necessary to add a fourth one, let us name it as (D) to the ABC steps above.

Therefore (D) would be the rolling out ARVs to lower viral load for patients on treatment. In this regard, Ruxin *et al*. proposed "simple antiretroviral protocols to reduce mother-to-child transmissions; and antiretroviral therapy to reduce morbidity and prolong lives of those who already have the virus." [1]

Abstinence from sexual activity is clearly the most effective method of preventing sexually transmitted HIV. Yet funding for applicable initiatives has seldom been prioritised in this respect. On one hand, from the onset of global interventions, condoms were seen primarily as most potent towards reducing the risk of infection. On the other hand, in due course, the implementation of Abstinence and Being Faithful (AB) initiatives by Churches among others, has since been seen as holding massive comparative advantage towards facilitating sustainable interventions for prevention and mitigation of the AIDS impact. However, many service providers offer the condom option in situations where abstinence is, in their perspective, deemed "unrealistic". Advert is a strong advocate of sexual education courses and suggested that comprehensive sex education for young people is an essential part of HIV prevention.

Transmission of HIV through blood is the most efficient and effective method of transmission. Those who are at greatest risk of contracting HIV through blood transmission are those who share needles, including needles for recreational drug use. Drug prevention is one solution to this problem, but drug users will always exist. According to Advert, needle exchange programmes have been shown to reduce the number of HIV infections and do not seem to encourage drug use. Injecting drug

[1] Emerging consensus in HIV/AIDS, malaria, tuberculosis, and access to essential medicines. Ruxin, Josh, *et al*. The Lancet (2005), Volume 365, Issue 9459 , 618 - 621

users should also be exposed to counselling and other intervention(s) in an effort to educate them properly regarding safe needle using habits. Direct transfusion of blood is the easiest way to transmit HIV, but rarely happens today with the screening and heat-treating of blood supplies. Screening is not 100% effective, but restrictions on those who donate blood help to eliminate the presence of HIV in blood reserves.

Furthermore, HIV through blood transmission can be reduced by the sterilization of instruments that come in contact with blood and the use of precautions and protective barriers for direct contact with blood. Mother-to-child transmission can occur at any time during pregnancy, labour, and delivery, and even during infancy when breastfeeding. A reduction in the number of women with HIV will naturally reduce the number of mother-to-child transmissions, so general HIV prevention measures indirectly will help prevent this method of transmission. If an infected woman becomes pregnant, several precautions help prevent the transmission of HIV to her child. Anti-retroviral (ARV) drugs can be administered during pregnancy and during labour, which can reduce the probability of transmission.

Single dosage of such drugs can reduce the probability of transmission in half (although multiple, longer-term dosages are much preferred). The actual delivery method of the child is an important consideration. Caesarean sections can reduce the baby's exposure to the infected bodily fluids of the mother, and thus lower the risk of transmission. Caesarean sections pose several risk factors to the mother, however, and should only occur when the infection level of the mother is high so that the benefit of such a procedure outweighs the potential risks.

Since breastfeeding can result in transmission of HIV from a mother to her child, the World Health Organisation (WHO) recommends that infected mothers not breastfeed their infants. Where healthy and safe alternatives to breastfeeding are not

available, however, mothers should breastfeed their babies since the risk of life-threatening complications from using unsafe alternatives might be higher than the risk of transmission through breastfeeding.

3.4 Religion and HIV/AIDS

Religious activities, communities, and beliefs frame the daily behaviours and attitudes of many people living in countries with high rates of HIV/AIDS. Several previous studies have called attention to the correlation between religion and behaviours that help to protect against contracting HIV. Much of the research in this area has focused on Muslim populations in African countries. It has been suggested that several religiously motivated behaviours practiced by Muslims are favourable for HIV prevention and have led to lower HIV prevalence rates among them (Gray, 2004).

Garner argued that the Pentecostal church's emphasis on salvation and strong social presence (e.g. youth groups, frequent prayer meetings) prevents members from engaging in as much extra- and pre-marital sex as other Christian denominations, thus protecting against HIV (Garner, 2000). However, strong religious beliefs do not always correlate with HIV protective behaviours. In a rural region of Senegal, Muslims and Catholics who considered religion "very important" were less likely to display HIV-preventive attitudes (e.g. intentions to change behaviour to protect against contracting HIV) than those who attached less importance to religion (Lagarde *et al.* 2000). In other studies, religious affiliation has been found to

correlate with level of HIV knowledge (Takyi, 2003 & Gender, 2005), but not necessarily with protective behaviours (Takyi, 2003).

Quite the opposite of the Garner study, Dollahite and Lambert, in a study *"Forsaking all others,"* utilising in-depth interviews of 57 Christian, Jewish and Muslim couples found that across the three religious faiths, couples drew strength from their faith to stay faithful in their respective marriages (Dollahite and Lambert, 2007). Using the criteria of: religious belief and practice; religious vows and involvement; couples' moral values which were strengthened by their religion; religious involvement, they established that these factors had a "sanctifying" effect on their marriages and therefore strengthened fidelity.

On the community level, religious organisations are influential social networks that have the power to support or stigmatize people living with HIV/AIDS (PLWHA), promote or impede HIV education, and endorse or reject medical treatment of HIV. In Tanzania and other countries with high rates of HIV, Faith-based Organisations (FBOs) are major providers of HIV/AIDS care, service, and education (Lagarde *et al.* 2003). Churches can give people support for both spiritual matters and daily material needs. They can provide PLWHA with spiritual counselling, prayers for healing, hope for personal spiritual salvation, social and material support, personalized care when they are sick, and assurances of burial after they die (Healing, 2007). On a regulatory level, some churches require or heavily encourage couples to be tested for HIV before getting married (Luginaah *et al*. 2005).

The sexual and moral connotations frequently associated with HIV transmission can also turn the church into a stigmatizing atmosphere for PLWHA. The perceived stigma occurs at all levels, from church leaders to congregation

members (Genrich & Brathwaite, 2005). Many of the stigmatizing attitudes towards PLWHA arise from people's beliefs that PLWHA have behaved immorally and their fears of acquiring HIV through casual contact with PLWHA (Luginaah, *et al.* 2003). This latter category of HIV stigma can be further broken down into stigma arising from shame about HIV and stigma arising from the tendency to attach blame to PLWHA ("Working report", 2005). Shame stigma is also important to understand in the context of organized religion. Shame about HIV is closely linked to internalized, self-directed stigmatization (Alonzo & Reynolds, 1995), which can lead PLWHA to withdraw from social settings such as their religious community. Fears of stigmatization and blame are also closely linked to disclosure intentions (Deribe *et al.* 2008) (Hutchinson *et al.* 2007).

Religious beliefs significantly shape individuals' outlooks on living with HIV. Faith practices and beliefs can provide a sense of peace and hope, and can also help people to prepare for and accept death (Genrich & Brathwaite, 2005). People often turn to religion to make sense of and come to terms with being HIV-infected. Prayer, meditation, faith in God, and other forms of religious participation have frequently been cited by PLWHA in Tanzania and other African countries as major strategies for coping with HIV/AIDS (Makoae, *et al.* 2008).

Studies conducted in the United States have found that PLWHA use religion to cope with their illness (Cotton *et al.* 2006) (KI, *et al.* 2004), that being diagnosed with HIV often strengthens people's faith (Cotton, *et al.* 2006) (Ironson *et al.* 2006), that an increase in spirituality/religiousness after being diagnosed with HIV is correlated with slower disease progression (Ironson, *et al.* 2006), and that spiritual beliefs about HIV influence end-of-life decisions (Kaldjian *et al.* 1998).

The studies discussed above provide a sound understanding of the connections between religion and beliefs about HIV and the general importance of FBOs. However, there are some insightful studies with a rather modest approach.

A. Krause & Hayward conducted a study '*Church based social support, religious commitment and health'* to track the "course of age-related changes in emotional and tangible support given and received by older adults in the context of their religious congregations." They applied a hierarchical linear modelling to data from a national sample of 1,192 White and African American older adults, who attended church regularly and who were interviewed up to four times over a period of seven years. They found that "religious factors, including frequency of attendance, commitment, and the congregational cohesiveness were strong predictors of between-person differences." They noted "patterns of increasing quantity and quality of emotional ties, but decreasing tangible support," noting that "these findings partially contrast with previous findings regarding secular support networks but are consistent with the socio-emotional selectivity perspective."[2] This does suggest religious commitment may enhance certain desirable outcomes but one may need to be very specific in identifying the exact aspects that are enhanced, if ever.

Mathews, DA *et al*. (1998) "*Religious commitment and health studies"* in the Archive of Family Medicine *(A review of the research and Implications for family medicine)* concluded that religious commitment may enhance certain desired outcomes in persons. In this case they refer directly to religious commitment as

[2] Hayward, R.D., & Krause, N., (2013). Changes in church-based social support relationships during older adulthood. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *68(1),*

85–96, doi:10.1093/geronb/gbs100. Advance Access publication November 12, 2012

playing a role in the enhancement of "illness prevention, coping with illness, and recovery." (Mathews, DA *et al.* 1998).

3.5 Faith-based Organisations on HIV/AIDS prevention

Faith-based Organisations (FBOs) have generated increasing interest as agents for preventing and mitigating the HIV/AIDS epidemic. Potential for success or actual success of FBOs in developing interventions, stems from several sources. FBOs often have extensive networks of people, institutions, and infrastructure, especially in rural areas, where few other such institutions exist. In many cases, members of FBOs demonstrate more commitment to their FBOs compared to other political, social and economic institutions. FBOs often have a direct impact on social institutions, such as schools, which socialize people and change values over time. In addition, their jurisdiction often includes a number of areas closely connected to HIV/AIDS, such as morality, beliefs about the spiritual bases of disease, and rules of family life and sexual activity (Liebowitz, 2002).

Dehaven *et al. 'Health programmes in FBOs: are they effective?'*[3] examined 386 published papers and selected 105 to show that according to these papers, FBO programmes generally can improve health outcomes but are modest not to claim clear causal links. They point to the need for increasing the "frequency with which such programs are evaluated and the results of these evaluations are disseminated."

[3] DeHaven, M. J., Hunter, I. B., Wilder, L., Walton, J. W., & Berry, J. (2004). Health Programs in Faith-Based Organizations: Are They Effective? *American Journal of Public Health*, *94*(6), 1030–1036

Asomugha *et al.* (2011)[4] '*FBOs, science and the pursuit of health*' bemoan what they term relatively few rigorous evaluations of the effectiveness of FBOs' work in addressing health and health care outcomes. In that vein they call for establishing "national faith-based health research network" to create an "evaluative infrastructure and generate new research on health programs and their effectiveness in FBO settings" (Asomugha *et al.* 2011).

Ferguson *et al.* in '*Outcomes, Evaluation in FB Social Services-Are we evaluating faith accurately?*' argue that no comprehensive review of the role of faith exists in faith-based work.

If the principal thought here is *comprehensive,* the view may be plausible. However, it might well be a generalisation by Ferguson *et al.* and if that be the case, the work of Grills (2007), who undertook an exhaustive qualitative research on *"Believing in HIV: The effect of faith on the response of Faith-based Organisations to HIV in India,"* disproves that position and confirms otherwise. Grills explored the critical role of faith, among FBOs (though admittedly, the study's limitation is that it was focussed on a particular geographical location) and concluded that faith was found to be not irrelevant, but instead, continued to influence most FBOs in terms of approach to HIV, resources available and "their moral ethical stances on issues such as corruption and condom promotion" (Grills, 2007).

Putnam's theory of social capital may help explain why religious institutions have, in some cases, demonstrated more effectiveness in combating AIDS than government or related institutions. Since, in many religious institutions, members

[4] Asomugha, C. N., Derose, K. P., & Lurie, N. (2011). Faith-Based Organizations, Science, and the Pursuit of Health. *Journal of Health Care for the Poor and Underserved*, *22*(1), 50–55. doi:10.1353/hpu.2011.0008

regularly engage themselves in activities that build trust and community within the religious institutions, they are more likely to use these religious institutions to accomplish social goals (Putnam, n.d.).

Putnam's argument agrees with that of Awusabo-Asare, who claims that "vertical communities" where members are united on the basis of a "shared identity and commitment, have been able to develop programs that have changed behaviour". (Awusabo-Asare, n.d.).

Caldwell also agrees, suggesting that in cases where organisations can build a sense of community (as often occurs with FBOs) they can achieve a sense of collective action, which is central to behaviour change (Caldwell, n.d.). The examples of Youth Alive (an FBO) and Straight Talk, which have both succeeded in building broad youth communities in Uganda, underscore this point (Cadwell, n.d.). FBOs are involved in significant and positive activities in AIDS prevention, care and support at the community level. The most common include: 1) Awareness/education; 2) Home care; 3) Counselling and supporting testing; 4) Food and material support and 5) Support for orphans. FBOs delivered a number of messages to congregation and community on HIV/AIDS.

The most common messages were abstinence; faithfulness; the importance of love, care and support for those infected; the importance of getting tested; using condoms; and not discriminating against those infected. Most FBO leaders identify home care and visitation programs as the ones in which congregation members have taken the most interest and in which they have participated the most fully. In some cases, congregation members initiated such programmes and often are entirely responsible for carrying them out. FBOs can be very effective in generating prevention messages that allow congregation members to develop their own

strategies for prevention. FBOs that can build the capacity of their congregation to respond effectively and appropriately to challenges of prevention will be performing a service that is in great demand (Liebowitz, 2004).

FBOs are categorised as follows (Birdsall, 2005):

- Networks and coalitions – associations of churches and other FBOs established to facilitate communication and coordination among members
- Governance bodies – national or provincial/regional structures within the religious denominations that have financial, administrative or doctrinal responsibilities
- Social service agencies – welfare and charitable wings of religious denominations that conduct outreach in the community on behalf of the church/religious group
- Faith-based NGOs – independent organisations that identify themselves as having a religious orientation
- Congregations – individual churches, parishes or religious constituencies and
- Projects – specific initiatives being conducted by Faith-based Organisation (or run independently, but with a faith orientation), such as children's homes, home-based care, soup kitchens, income-generation projects and others.

3.6 Church/ Congregations As Providers of HIV/AIDS Care

Congregations are value-based organisations with an effective infrastructure that is in touch with realities on the ground and can reach out to every household in the community (Hendriks, Erasmus, & Mans, n.d.). Leaders at the congregational level

have frequent contact with members; they are also highly esteemed and are among the most influential members of their communities (Pfeiffer 2004b).

In setting an agenda for the study of religious organisations in the United States, Chaves (2002) distinguishes between three distinct types of religious organisations: congregations, denominational organisations, and religious non-profits. Religious congregations are defined as "relatively small scale, local collectivities and organisations through which people routinely engage in religious activity: churches, synagogues, mosques, temples".

The word "Church/Congregation" encompasses an ill-defined environment. What Church is and stands for, is unique to each person's perception. Smit (1996:119-129,190-204) wrote two informative articles about the uniqueness of the Church. He described six "statures" of the Church, as an operational concept. A Church is:

- A worshipping community – this refers to the Sunday worship service.
- Secondly, "Church" refers to the local Church. In this study, we refer to this stature of the Church as a congregation.
- Church also refers to a denomination. A group of local Churches or Churches in a specific area organise themselves to work together. In our study, we received the cooperation of all denominations.
- Church means an ecumenical body. Different Churches and denominations meet to advocate a very important issue, for example unemployment, HIV/AIDS or sexual violence.
- Church also implies members involved in volunteer organisations, civil initiatives and associations.

- Lastly, the Church comprises individual members who live according to the values of Christianity in their everyday lives (1996:120-121).

In a rigorous review of 36 selected peer-reviewed HIV studies, Campbell *et al*. (2011) referred to 'the Cartography of HIV and AIDS, Religion and Theology', a bibliography by the University of Kwazulu Natal which has identified 1,779 resources related to AIDS and religion. They reviewed specifically the role of church groups /congregations in Sub-Saharan Africa as social spaces to tackle AIDS related stigma. They bemoaned some nuanced historicity of AIDS related stigma promulgated incidentally, in some church settings. They argued that this is mainly due to the fact that HIV/AIDS has often been interpreted in the context of 'a conservative church morality' that 'typically includes the stigmatisation of sexuality, particularly the sexuality of women and young people'.

Campbell *et al.* contend further that as 'HIV-infection is primarily transmitted through sex, which typically churches emphasise should only occur in the marriage of a sexually monogamous man and woman, people come to understand and associate HIV/AIDS with immoral behaviours, linked to the underlying assumption that HIV/AIDS should not be a risk for those who adhere to the teachings of the church '.

However, Campbell *et al.* conclude their review with a fair enumeration of evidence pointing to the important contributions of church congregations towards curbing the spread of HIV infections and provision of care and support to AIDS sufferers and those around them. They concede that 'even amidst much evidence for their role in perpetuating stigma and undermining prevention efforts, there is also much evidence for church groupings contributing to the care and support of those infected and affected by HIV/AIDS'.

Acknowledging the findings of a study by Becker and Geissler (2007:36) who concluded that 'church groups are ideally placed' to make such contributions 'through their commitment to traditional values of solidarity as well as the fact that they are truly community-based', Campbell *et al.* also drew attention to the study by Adogame (2007:12) who investigated the work of the Redeemed Christian Church of God in Nigeria. He argued that 'Pentecostal churches, whose conceptualisation of disease and healing is central to their response to HIV/AIDS, need to be acknowledged for their efforts to combat the epidemic and provide care and support for those infected'.

Campbell *et al.* showed a link between Adagome's findings, whom they indicated, drew on qualitative data gathered from Malawi by Trinitapoli (2006:47; 2009:) who found that 'many church groups in rural Malawi are involved in caring for the sick, sponsoring HIV/AIDS education programs for youth, and emphasizing the care of orphans as a religious responsibility'.

Campbell *et al.* also highlighted a study in Botswana by Dahl (2009:56) which observed that 'in the context of modernity and changes to traditional values and customs—Christian values may provide a framework that enables poor communities to cope with the care and support of children affected by AIDS'. Another study highlighted looked at Church members in Ghana where Bazant and Boulay (2007:11) found that 'the greatest contributing factor to the care and support of PLWHA by church group members was whether respondents had heard their leader publicly speak about HIV/AIDS'.

The review by Campbell *et al.* (See summary in Table 8 below) is significant as it points insightfully to another important reality regarding church congregations,

noted by Agadjanian and Sen (2007:36) who in their study in Mozambique found 'the involvement of church groups in the provision of assistance to be limited to psychological support and personal care, neglecting many of the material and financial needs of those affected.'

However, their assumption that 'this probably partly reflects the poverty of many churches and church members, but could also be an indicator of resource-based stigma' (namely the belief that PLWHA do not deserve material support or services) is challenged later in this study. Notwithstanding the afore-noted, the finding that 'financial constraints and institutional rivalry' could be 'a hindrance to the cooperation of religious organizations in the provision of assistance to PLWHA' confirms findings of this study as discussed later also.

Table 8: Summaries of 34 out of 36 included studies (Source: Campbell *et al*.)

Authors	Location year	Study aim	Type of study	Methods, sample size	Main findings
Par**sitau**	Kenya	To examine how Pentecostal churches respond to the AIDS epidemic	Qualitative	Ethnographic observations and participation in church activities. Interviews with church leaders, members and non-members	The Pentecostal church responds to the AIDS epidemic through the promotion of HIV prevention messages. However, these messages tend to overlook the complexities of people's life situations, making it difficult for members to engage with the messages that they convey
Haddad	South Africa	To examine the role of, and changes in, the church in light of the AIDS epidemic	Review	Ethnographic observations and review of the literature	At a community level, church leaders are found to take a positive and active role in HIV prevention efforts. At an institutional and theological level, a commitment to support PLWHA remains limited
Black	Kenya	To communicate ways in which religious leaders can become partners in HIV prevention	Qualitative	Ethnographic observations and participation in a programme to teach pastors the facts about HIV/AIDS	A programme training pastors to take an active role in HIV work has been implemented, highlighting their wiliness to participate as partners in prevention

Authors	Location year	Study aim	Type of study	Methods, sample size	Main findings
Miller and Rubin	Kenya	To examine factors leading to disclosure of HIV status	Qualitative	Groups discussion (n = 4) with PLWHA	PLWHA communicate their status using indirect language and often disclose their HIV-positive status to church pastors
Dilger	Tanzania	To examine how a church can give meaning and orientation amidst AIDS and poverty	Qualitative	Ethnographic observations of church activities and interviews with members of a Neo-Pentecostal church	In changing times it is increasingly attractive to be a church member because of the networks of healing and support that are available
Sadgrove	Uganda	To examine how Pentecostal peer and youth groups negotiate social and sexual behaviours	Qualitative	Ethnographic observations, encompassing 10 months of observations of 25 university students	Although church groups can foster social control of sexual behaviour, the effects of such control may not always favour HIV prevention
Smith	Nigeria, 2001-2003	To examine the HIV/AIDS related beliefs and behaviour of Christian youths	Quantitative and qualitative	Survey (n = 863) and individual interviews (n = 40) with young migrants and participant observation	Popular religious interpretations of HIV risk lead many young people to imagine themselves as at little or no risk—undermining HIV-preventive behaviours
Santmyire and Jamison	Burkina Faso, 2005	To examine a training programme of pastors on mother-to-child transmission	Quantitative	Pre- and post-test examinations of training programme and a follow-up, self-administered evaluation form	The training programme successfully improved pastors' knowledge of HIV/AIDS and mother-to-child transmission
Becker and Geissler	East Africa	To explore how AIDS is understood and confronted through religious ideas and practices	Review	Introduction to a special issue	Religion is intrinsically linked to how people in Africa are thinking and responding to AIDS. Religious organisations and views are not as ignorant and bigoted as AIDS educators often believe
Garner	South Africa, 1999-2003	To explore the pathways through which religious denominations sustain or mitigate HIV risk behaviours	Quantitative and qualitative	Ethnographic observations (N = approx. 45 church visits), survey (N = 334 households) and individual interviews (N = 78)	Only the Pentecostal churches are found to reduce levels of extra- and pre-marital sex. They do this through indoctrination, religious experience, exclusion and socialisation
Addai	Ghana	To examine the role of religious affiliation on sexual initiation among Ghanaian women	Quantitative	Demographic and Health Survey data from 1993	Religious affiliation is an important predictor of premarital sex, particularly among ever-married women
Adogame	Nigeria	To examine how African Pentecostals have sought to combat the AIDS epidemic and provide support for	Qualitative	Ethnographic observations, encompassing accounts from church leaders and community	The Pentecostal church under study has shown commitment to contributing to HIV prevention and has offered spiritual and

Authors	Location year	Study aim	Type of study	Methods, sample size	Main findings
		AIDS-affected people		members as well as church documents and media material	medical support
Regnerus and Salinas	Ethiopia, Kenya, Malawi, Namibia, Zambia, Zimbabwe	To examine the extent to which religious affiliation contributes to stigma and discriminatory attitudes	Quantitative	Demographic and Health Survey data from six countries	Religious affiliation is generally unrelated to discriminatory attitudes. Where affiliation is significant, non-Christian religions tend to report more discriminatory attitudes
Agadjanian	Mozambique, 2003	To examine how religious participation influences gender differences in views of HIV/AIDS and prevention choices	Quantitative and qualitative	Survey (n = 731) and individual interviews (n = 58) with men and women	Women have lower levels of knowledge of AIDS and perceptions of own risk. Gender differences are more pronounced in 'healing' (e.g. apostolic) churches than in 'mainline' (e.g. catholic) churches
Agadjanian and Sen	Mozambique	To examine the role of religious organisations in the provision of HIV/AIDS related assistance	Quantitative and qualitative	Survey (n = 677) with parishioners and individual interviews (n = 57)	Religious organisations only provided limited help to AIDS sufferers, mostly through psychosocial care and household help, and rarely materially
Agha *et al*.	Zambia	To determine the links between religious affiliation and HIV risk, sexual initiation and condom use	Quantitative	Survey (n = 5534) with women aged 13-20	Affiliation with conservative religious groups is unlikely to reduce the risk of HIV infection as they encourage conflicting behaviours that cancel each other out
Allman *et al*.	Nigeria	To explore socio-demographic (including religion) characteristics and HIV risk amongst men who have sex with men	Quantitative and qualitative	Self-completed questionnaires (n = 58) and five focus group discussions (n = 58) with men who have sex with men	Same-sex community networks are hidden and ostracised by religious institutions
Bazant and Boulay	Ghana, 2003	To identify the factors associated with church members' support of PLWHA	Quantitative	Survey (n = 1200) with members of six religious congregations	Local and religious leaders can influence community dialogue, collective action, and individual behaviour change
Dahl	Botswana, 2003-2008	To examine changes in Tswana 'culture' and perspectives about the role of Christianity in responding to the AIDS pandemic	Qualitative	Ethnographic observations, including attending church services, interviews and media analysis	In response to a declining influence of moral tenets of Tswana culture and kinship, which AIDS-affected people rely on for support, Christianity resurrects a new moral order that promotes care and support
Gregson *et al*.	Zimbabwe, 1993-1996	To examine the influence of religion on demographic changes (e.g. death	Quantitative	Cross-sectional and retrospective survey (n = 2512) as well as data	Restrictive norms on alcohol consumption and extra-marital relationships in 'spirit-

Authors	Location year	Study aim	Type of study	Methods, sample size	Main findings
		due to HIV)		from demographic health surveys	type' churches (e.g. Apostolic, Zionist) may limit spread of HIV
Gusman	Uganda, 2004-2007	To examine changes within the Pentecostal churches in Uganda in the era of AIDS	Qualitative	Ethnographic observations, especially participation in church activities	Young people's involvement in religious activities and campaigns against AIDS parallels the Pentecostal 'break with the past', stimulated by social changes brought about as a result of the HIV epidemic
Haddad	South Africa	To examine the role of church leaders in responding to HIV/ AIDS	Qualitative	Individual interviews (n = 16) with church leaders	Whilst church leaders tend not to condemn HIV risky behaviour, they are slow to respond with effective strategies
Haddad	South Africa, 2004-2006	To examine how women leaders of prayer unions have experienced the HIV epidemic	Qualitative	Individual and group interviews with men (n = 16) and omen (n = 12) leaders of prayer unions	Women leaders of prayer unions create supportive social spaces for young people to confide their fears and where HIV and AIDS can be theologised
Hartwig *et al*.	Tanzania, 2003	To examine ways church leaders can confront HIV/AIDS and stigma	Qualitative	Individual interviews (n = 15) with church leaders	Facilitating spaces where church leaders can discuss HIV can create opportunities for reflection and compassion
Lagarde *et al*.	Senegal, 1997	To describe the association between religion and factors contributing to HIV transmission	Quantitative	Cross-sectional survey (n = 858) and individual interviews (n = 54) with church-goes and leaders	Religion was not significantly associated with AIDS awareness or intentions to engage in sexual fidelity to protect themselves from AIDS
Maman *et al*.	Democratic Republic of Congo, 2006	To examine how women's faith and their religious leaders have helped them disclose and cope with their HIV status	Qualitative	Individual interviews (n = 40) with HIV positive women who recently gave birth or were pregnant	Women were able to turn to church leaders for advice about disclosing their status to others. Having faith played an important role for the women's long-term coping strategies
Marshall and Taylor	Burkina Faso, Zimbabwe and South Africa	To examine what churches were doing to respond to AIDS and gender inequalities	Qualitative	Individual interviews with key staff from 24 organisations	Churches were largely silent on the issue of gender and sex and were found to reinforce traditional values which potentially contribute to HIV infection
Otolok-Tanga *et al*.	Uganda, 2003	To explore perceptions of the roles of faith-based organisations in HIV work	Qualitative	Individual interviews with non-faith-based (n = 22) and faith-based (n = 8) external change agents	Although faith-based organisations were slow to respond to AIDS epidemic, they are now in a committed/good position to contribute to HIV work
Pfeiffer	Mozambique, 1998-2002	To explore the dangers of condom social marketing at the expense of	Qualitative and quantitative	Individual interviews (n = 208) with key informants and	A condom advertising campaign clashed with Pentecostal church teachings, spreading a

Authors	Location year	Study aim	Type of study	Methods, sample size	Main findings
		community dialogue		community members, group discussions (n = 8) with women's and youth groups and a survey (n = 616)	contrasting message about sexuality and risky behaviour
Plattner and Meiring	Namibia	To explore how PLWHA cope and give meaning to being HIV positive	Qualitative	Individual interviews (n = 10) with people living with HIV	Religious beliefs made their HIV status more meaningful and brought a sense of purpose to their HIV infection
Takyi	Ghana, 1998-1999	To examine the interrelationship between religion and AIDS behaviour	Quantitative	Ghana Demographic Health Survey (n = 4843) with women	Christian women reported higher levels of knowledge than their non-Christian counterparts. Religious affiliation had no effect on changes to behaviour, particularly condom use
Watt *et al*.	Tanzania, 2006-2007	To examine how religion influences PLWHA with the aim of identifying opportunities for religious organisations to support PLWHA	Qualitative	Individual interviews (n = 36) with PLWHA who go to church	At the informal level, personal faith positively influenced PLWHA and their experiences with HIV. However, formal religious organisations had either a neutral or negative influence on the lives of PWLHA
Zou *et al*.	Tanzania	To investigate associations between religious beliefs and HIV stigma, disclosure, and attitudes towards AIDS treatment	Quantitative	Self-administered questionnaire (n = 338) amongst parishioners	While religious beliefs did not affect decisions to start AIDS treatment, they were associated with stigmatising attitudes against PLWHA and also with PLWHA's willingness to disclose their HIV status

3.7 SUMMARY OF CHAPTER 3

The literature review covered the current HIV/AIDS problem in Zambia, followed by interventions for prevention, treatment, and care of HIV/AIDS. Specific studies regarding particular interventions and general HIV prevention were reviewed and discussed. Finally, perspectives on Faith-based organisations were highlighted, their comparatively unique interventions and those of church congregations elaborated and augmented with a description of six "statures" of an operational concept of the church.

The current literature suggests that church congregations by their very nature provide a variable of social factors that can mitigate the spread of HIV. By the same token, the literature suggests that church congregations can also engage in specific interventions that reduce stigma, promote abstinence and fidelity, and enable members to develop their own home grown strategies of AIDS prevention.

This study will examine whether interventions affect impact in congregation-based HIV/AIDS interventions and seek to identify any causal factors responsible for increased impact of congregation-based HIV/AIDS interventions, while assessing the magnitude of impact for The Circle of Hope interventions.

Although there is now a growing body of desk reviews and surveys covering the important role of faith-based organisations including Muslim mosques and Christian churches in the fight against the spread of HIV in a number of African countries, this study is the first of its kind to attempt measuring actual impact of congregation-based HIV interventions in a Pentecostal Christian church setting in Lusaka, Zambia. It draws on baseline and follow-up field data gleaned from an experimental design that includes a researched intervention group on one hand as well as a non-intervention control group on the other.

The findings of this study form an important point of departure for further in-depth research work exploring the unique dynamics presented by Christian congregations in Zambia. The study makes also makes a unique contribution to the body of knowledge by being located around a Pentecostal congregation-based initiative that originated and evolved naturally from within the grass-root efforts of the researcher and AIDS infected/affected congregants who became part of the formation and implementation of the main interventions under investigation.

This is in direct contrast with many studies that tend to be initiated by enquirers and researchers from outside and are sometimes perceived as driven more by funding than genuine need to make a difference in the respondent communities. The study is, in one sense, a practical fruition of the adage *'necessity is the mother of invention'*. Chapter 4 will describe in greater detail the methodology chosen for this study.

CHAPTER 4: METHODOLOGY

This chapter details the specific methods and designs of the study and explicates how the research process was executed. It also describes the main intervention for the study and briefly discusses how the challenges were addressed. Ethical considerations are also highlighted.

One of the main objectives of this study was to determine how interventions affect impact in congregation-based HIV/AIDS interventions. The study also intended to identify any causal factors responsible for increased impact of congregation-based HIV/AIDS interventions and to assess the magnitude of impact for COH interventions. A quasi-experimental research design was chosen in order to compare a treatment and control group with one another to determine any significant differences between the two groups. The analysis conducted for this quasi-experimental design consisted of two stages.

Firstly, cross tabulations were used to examine the relationship between safer sexual behaviour and socio-economic variables. For the statistical analysis, *chi-square* tests of independence were conducted at the bivariate level, and the differences were determined at $P < 0.01$ and $P < 0.05$ significant level.

Secondly, major predictors were carried out with the help of logistic regression analysis. The results of the logistic regression models were converted into odds ratios, which represented the effect of a one-unit change in the explanatory variable on the indicator of experiencing safer sexual practices [including marital fidelity] and abstaining from sex. Odds ratios larger than one indicate a greater likelihood of experiencing safer sexual practices and abstaining from sex than for the

reference category; odds ratios smaller than one indicate a smaller likelihood compared to the reference category.

This chapter will discuss the research methods and design that were chosen for the study as well as the target population, the sampling plan, the measurements and the variables included in the analysis. The chosen statistical technique will be described again.

4.1 SPECIFIC RESEARCH METHODS AND DESIGN

The research elected a quasi-experimental design for the study, interviewing and coding to provide *before* and *after* measures for a treatment cohort and a control group. This allowed for quantitative and qualitative analysis of responses. The Circle of Hope programme as a whole was chosen as the central location and focal point of reference, a *defacto* case study, being a congregation-based and faith-based initiative that combines palliative care and efforts to reduce transmission of HIV through altering risky behaviour.

As George and Bennett (2004) noted, in apparent reference to Harry Eckstein in Greenstein and Polsby, eds (1975), case study methods "serve the heuristic purpose of inductively identifying additional variables and generating hypotheses ... [as they] can analyse qualitatively complex events", "test causal variables" and create "sub-types and differentiating variables." By contrast, they contended: "statistical methods lack accepted procedures for inductively generating new hypotheses." They posited instead that case studies "take into account numerous variables precisely because they do not require numerous cases or a restricted number of variables."

George and Bennett (2004) argued that case study researchers are "…also not limited to variables that are readily quantified or those for which well-defined data sets already exist." As the study seeks to investigate an understudied area of faith-based and congregation-based response, an additional advantage of the methodology George and Bennett lay out is that it is appropriately "pedagogical."

Further, this also enables the researcher to compare an independent variable (treatment cohort and a control group) with that of a dependent variable (abstinent before marriage, being maritally faithful, lifestyle and so on) that has been measured after an intervention has been used (Cozby, 2001). When the independent variable is categorical (i.e. has two or more specific categories) the researcher can examine any differences between the two groups (Moore & McCabe, 2006). In other words, in the context of this study, the researcher can determine whether there are differences between the treatment cohort and a control group when it comes to the abstinent before marriage, being maritally faithful, lifestyle factors and so on. Some measurements obtained from the survey instrument designed for this study are empirical in nature.

The research design initially was quantitative only. However, further reflection raised the need to gather qualitative data as well, thus necessitating a mixed methodological approach. Out of six known basic prototype versions of mixed methods designs (Creswell & Plano Clark, 2011) commonly used by researchers, the convergent parallel design[1] was chosen as the most suited for this study as its

[1] The others prototypes being: the explanatory sequential design, the exploratory sequential design, the embedded design, the transformative design, and the multiphase design. See John W. Creswell & Vicki L. Plano Clark, (2011) "Designing and Conducting Mixed Method Research", 2nd Edition. Sage Publications, Inc. Thousand Oaks, California, pp 66 -106.

"purpose is to obtain different but complementary data on the same topic" (Morse, 1991 in Creswell & Plano Clark, 2011) best to grasp the research problem.

Creswell and Plano Clark explained that scholars began to discuss this design, which was initially conceptualised as a "triangulation" design, as early as 1970, making it "probably the most common approach across disciplines." They clarified that the convergent parallel design happens "when the researcher collects and analyses both quantitative and qualitative data during the same phase of the research process and then merges the two sets into an overall interpretation."

Thus, the goal in using this design is to "bring together the differing strengths and non-overlapping weaknesses of quantitative methods …with those of qualitative methods" (Patton, 1990 in Creswell & Plano Clark 2011). The researcher here seeks to triangulate the methods by directly comparing and contrasting the quantitative statistical results with qualitative findings for corroboration and validation purposes (Creswell & Plano Clark, 2011). Other purposes for this design in line with what is highlighted by Creswell & Plano Clark are "illustrating quantitative results with qualitative findings, synthesizing complementary quantitative and qualitative to develop a more complete understanding of a phenomenon, and comparing multiple levels within a system."

However, the convergent design is not without challenges. Creswell & Plano Clark listed the following challenges facing researchers using the convergent design and suggested options for addressing the said challenges (some quoted Verbatim):

In view of the fact that the design involves the collection of concurrent data and that equal weight is given to each data type, "much effort and expertise is required." This can be addressed by forming a research team that includes members who have quantitative and qualitative expertise, by including researchers who have quantitative

and qualitative expertise on graduate committees, or by training single researchers in both quantitative and qualitative research.

Researchers need to consider the consequences of having different sample sizes when merging the two data sets. Different sample sizes may arise because the quantitative and qualitative data are collected for different purposes (generalization vs. in-depth description, respectively).

It can be challenging to merge two sets of very different data and their results in a meaningful way. Researchers need to design their study so that the quantitative and qualitative data address the same concept. This strategy facilitates merging the data sets.

Researchers may face the question of what to do if the quantitative and qualitative results do not agree. Contradictions may provide more insight into the topic, but these differences can be difficult to resolve and may require the collection of additional data. The question that develops at this point is what type of additional data to collect or reanalyse: quantitative data, qualitative data, or both?

Figure 5 (below) represents a flow chart of the basic procedures in implementing a convergent parallel design.

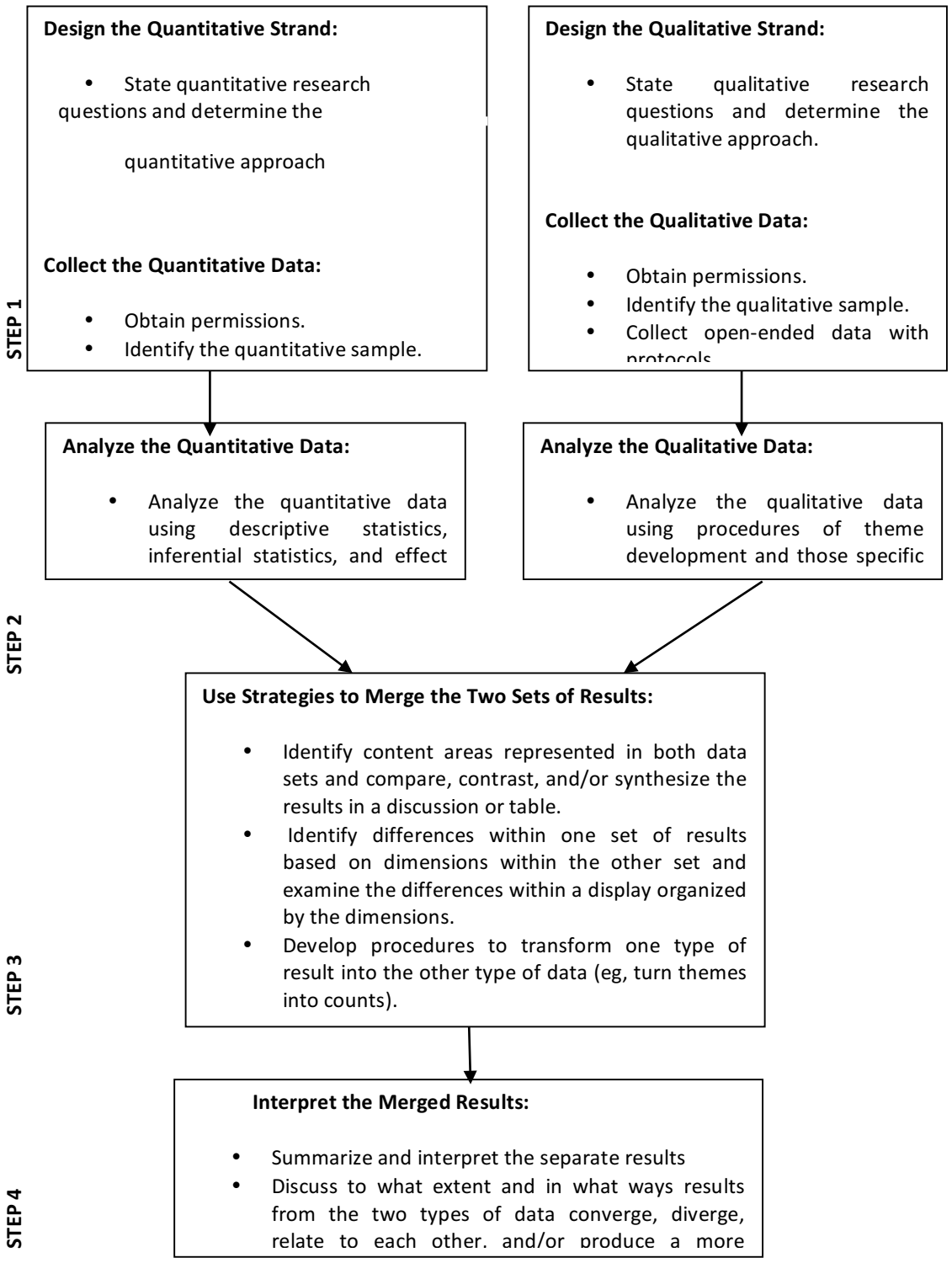

Figure 5: Flow Chart of the Basic Procedures in Implementing a Convergent Design (Source: Creswell & Plano Clark, 2011)

Having established the fundamental basis for the mixed method design, a further reflection on the rationale for the quantitative aspect of the study is necessary. The research design is partially quantitative because a comparison was necessary between the treatment cohort and the control group. This enabled the researcher to assign quantitatively, numerical or unique values to the two groups so that a comparison could then be made.

The values for the independent and dependent variables were obtained by using a survey instrument that was designed to measure different factors that contributed to the abstinent before marriage, being maritally faithful, lifestyle and other dependent variables in the study. The study then compared a cohort of non-residential HIV+ patients on treatment at COH with a control cohort of non-patients (but affected by HIV), and [purposefully] selected within the Makeni community. Both groups were interviewed to provide a baseline, and again within 3 months. Focus groups were also used to target prioritised variables and topics.

An observational or descriptive study design could have been considered for this study; however, the researcher would not be able to determine whether there was a significant difference between the treatment cohort and the control group when it comes to the abstinent before marriage, being maritally faithful, lifestyle and other dependent variables. This is because the purpose of the observational or descriptive design is just to observe and record information about the participants rather than determine whether there is a significant difference or relationship between two variables (Cozby, 2001). Therefore, by using only an observational or descriptive study design the researcher would not be able to determine whether the treatment cohort and the control group were significantly different from one another with respect to their scores for the dependent variables.

To address the objectives of this study the data analysis was carried out in two stages comprising first, *cross tabulations* to examine the relationship between safer sexual behaviour and socio-economic variables. For the statistical analysis, *chi-square* tests of independence were conducted at the bivariate level, and the differences were determined at $P < 0.01$ and $P < 0.05$ significant level.

Next, major predictors were carried out with the help of logistic regression analysis. The results of the logistic regression models were converted into odds ratios, which represented the effect of a one-unit change in the explanatory variable on the indicator of experiencing safer sexual practices and abstaining from sex. Odds ratios larger than one indicate a greater likelihood of experiencing safer sexual practices and abstaining from sex than for the reference category; odds ratios smaller than one indicate a smaller likelihood compared to the reference category. The main research questions for the study follow below.

4.2 RESEARCH QUESTIONS

MAIN QUESTION: Is a person's sexual behaviour influenced by their attitude and behaviour towards God?

SUBSIDIARY QUESTIONS: a) What are the factors that affect a person's sexual lifestyle? b) Does attendance at the church's HIV/AIDS programmes cause a change of behaviour in a person's sexual relationships?

4.3 TARGET POPULATION

The target population for this study were members of the Circle of Hope (COH) Family Care Centre situated in Makeni, eight (8) kilometres South West of Zambia's

Capital City, Lusaka, and in the heart of a residential of predominantly low-to-middle income house-holds with a population of over 15,000.

4.4 SAMPLING PLAN

For the purpose of the study, a convenience-sampling plan, which is a form of non-probability sampling, was used. This is because the convenience-sampling method has an advantage over a probability sampling method (i.e. random sampling technique) in that the researcher would be able to obtain more participants in a shorter period of time (Cozby, 2001). Similarly, the convenience-sampling plan is appropriate for this study since the participants from COH would not be randomly selected from the entire population. Rather the COH members were selected based on whether they voluntarily chose to participate in the study or not. Another factor that necessitated this approach was cost limitation which meant the study could not be funded adequately otherwise within the period of execution.

However, being aware of the challenges and weaknesses that face non-probability sampling techniques like convenience sampling, chiefly the danger of selection bias (King *et al*. 1994), the researcher selected the guidance given by King *et al.* (1994) in *Designing Social Inquiry- Inference in Qualitative Research* and Skowronek and Duerr (2009) in the *Convenience of Non-probability Sampling* and took the following precautionary steps at the very start of the study, to ensure required rigour was sustained:

Design of the Survey Instruments must ensure sample representativeness: Skowronek and Duerr (2009) stated, "*studies that use convenience sampling should attempt to reduce selection bias and strengthen the study's usefulness by controlling*

and assessing the representativeness of the survey sample." While acknowledging that "*perfect designs*" may not be *"attainable,"* King e*t al*. (1994) suggested the need for researchers to *"allow for the possibility of at least a variation on the dependent variable"* as one way avoiding selection bias.

Taking the afore-going into account, the researcher applied extra care during the design stage of the survey instruments for both the quantitative and qualitative data to be collected. Therefore, the instruments were vetted by the supervisors of the study who possess due expertise. The proposal and instruments were also presented for scrutiny to the Biomedical Ethics Research Committee of the University of Zambia until the approval was granted. Hence, the demographics sections of the instruments were designed intentionally to allow early insight at base line to see whether the sample was sufficiently representative.

Ensuring Diversity: Skowronek and Duerr (2009) referred to Patten (2002)[2] by suggesting, "*Diversity also adds strength to convenience samples."* They suggest, for instance, the possibility of administering questionnaires at high traffic periods to allow for such diversity. In the case of this study, diversity was assured by the fact that the COH caters for a catchment area of over 25,000 people of diverse backgrounds. Their visits are random enough for sampling. Additionally, for this study only the 85 average number that were enrolled in the focus discussion groups could consider themselves as belonging to or being part of the clinic family. The rest of the participants were recruited from the vicinity on the basis of their willingness to participate and not necessarily by having a connection with the COH even though it

[2] Mildred L. Patten, *Proposing Empirical Research: A Guide to the Fundamentals* 2nd ed. (Los Angeles: Pyrczak, 2002), 65.

was the Centre for the main intervention. Another factor that assured minimization of selection bias was that, after the training of the research assistants, the researcher receded from the actual recruitment of participants so that enrolment would be objectively based on the criteria on the instruments and in conformity with the research objectives. The background characteristics of the total sample eventually recruited, both for the Intervention and the Control group are presented in the Results chapter. The diversity level was adequate.

Data Usage: Skowronek and Duerr (2009) suggested yet another way, "*to control uncertainty and bias is to use more data. One tactic for incorporating more data is to use larger samples. As a general rule for sample size, larger is better."* This study achieved this by ensuring a successful enrolment of almost double the minimum number (64 for the intervention and 64 for the control group) that was ascertained as required for the research (See next section on sample size). Additionally, the mixed method approach was partially chosen to allow for more comprehensive availability of data for analysis. The experimental design was also taken as a further strength.

The research commenced with a pre-test based on analysis of existing COH records. Questionnaires (see Appendix) developed for this study were used along with an interview methodology to conduct *before* and *after* measurements on 122-102 (i.e. base line and follow-up, respectively) COH participants and 135-114 persons (i.e. base line and follow-up, respectively) in control groups. Focus group discussions with guided questions were conducted among the 85-member support group of community members who meet monthly at the COH centre. The measurements were three (3) months apart.

4.5 SAMPLE SIZE

When calculating the sample size for a study, three factors have to be taken into consideration. The first factor is the power of the test, which measures the probability of rejecting a false null hypothesis and is usually set at 80% (Keuhl, 2000). For the purpose of this study a power of 80% was selected because a power of this magnitude adequately rejects a false null hypothesis (Moore & McCabe, 2006).

The effect size of the study is the second factor that has to be taken into consideration. The effect size is a measurement of the strength or magnitude of the relationship between the independent and dependent variables in the study (Cohen, 1988). Cohen (1988) defined the effect size for different tests into three different categories, which include a small effect, moderate effect and a large effect. For the purpose of this study, a medium effect size was selected since this once again would provide evidence of a relationship between the independent and dependent variables without being too strict or too lenient.

The final factor that is important is the level of significance. This is the probability of rejecting a true null hypothesis and is usually defined as being equal to 5% (Moore & McCabe, 2006). For this study the level of significance was selected to be equal to 5% since this is most consistently used.

The sample size would also depend on the type of analysis that is being conducted. Based on this information, the minimum sample size that was determined for this study was 128 (64 in the treatment cohort and 64 in the control group). The size of the sample required to achieve the objective of the study was scientifically determined using the 95% confidence level and a $\pm 10\%$ margin of error. The sample size was then obtained by using estimated proportions, whose variance, under

the assumption of simple random sampling, was given as s^2=pq, where *p* is an estimate of the proportion of the population that has the characteristic of interest or the probability of success and q = 1-p. The safest choice was when p=0.5. After fixing the desired precision ($\pm 10\%$ margin of error and 95% confidence interval), then the simple random sample size was computed as $n_1 = \frac{z^2 pq}{d^2}$, where z = 1.96 for a 95 % confidence interval and d = the specified margin of error. n_1 is therefore

$$\frac{1.96^2 * 50^2}{10^2} = 96$$

The simple random sample size in this case is 108 respondents. It is noted that the calculation above expresses d, p, and q as percentages. Adjusting this by the non-response rate, an approximate sample in the range of 128 respondents was arrived at. This was based on a two-sided alternative that states that there will be a relationship between the variables rather than stating there will be a positive or negative relationship.

4.6 MEASUREMENTS AND VARIABLES

Primary measurement instruments included carefully designed questionnaires encompassing open-ended and more precise forced response questions administered by trained research assistants on behalf of the Researcher. The forced response questions that were used and developed for the survey were comprised of Likert-type questions that range from a minimum of 1 which represents “Strongly Disagree: to 5 which represents “Strongly Agree”. The questionnaires featured open-ended questions covering a range of variables. Before and after measurements engaged

122-102 COH participants constituting the experimental cohort and 135-114 persons in the control cohort, following which cumulative data was then compiled for analysis.

Key independent variables included provision of medical treatment, personal home visits, counselling, personal faith, personal prayer, community consensus, response to teachings/sermons on salvation, holiness and moral purity, membership in congregation-based peer groups, family prayer, knowledge of personal HIV status, and participation in advocacy and education efforts by HIV+ participants.

Key dependent variables included adherence to an AB (Abstinent before marriage, being maritally faithful) lifestyle, longevity, morbidity, increased levels of hope, happiness and productivity, and decreased likelihood of spreading the virus. Some variables such as happiness, hope, productivity, longevity, adherence to a faithful or abstinent lifestyle, and advocacy by HIV+ participants may be analysed both as dependent and independent variables.

The operationalisation of the independent variables depended on the questions that were provided on the survey instrument (i.e. continuous, interval, ratio or categorical, nominal, ordinal). The dependent variables in the study were operationalised as continuous variables. An example of how the dependent variables are operationalised as continuous variables follows.

Say there were five questions on the survey instrument used to measure the personal faith of the participants. As stated earlier, these questions are then based on a five point Likert scale[3] where 1 is "strongly disagree" to 5 being "strongly agree".

[3] The format of a typical five-level Likert item is: Strongly disagree; 2. Disagree; 3. Neither agree nor disagree; 4. Agree; 5. Strongly agree. Likert scaling is a bipolar scaling method, measuring either positive or negative response to a statement. Sometimes a four-point scale is used; this is a forced

An individual was then observed to provide responses of 2, 5, 4, 3, and 4 for the questions on the survey. In order to obtain an overall measurement for the personal faith, the scores for this particular individual was be averaged. As a result, the scores for personal faith of this individual would be 3.6. A higher score would indicate that the subject has higher personal faith, whereas a lower score would indicate the opposite.

4.7 DATA COLLECTION

Data for this study was obtained through the use of questionnaires developed specifically for this purpose as well as the responses and information collected from the focus group discussions held with the 85 COH community members. Prior to any information or data being collected from the potential participants, each respondent was availed an Information Sheet providing basic information about the study and what their participation entailed. They were duly required to sign (or thumb print) this sheet as well a Consent Form on which they acknowledged understanding that the researcher assured them adherence to the highest standards of ethics in all attendant processes related to their participation in the study.

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choice method since the middle option of "Neither agree nor disagree" is not available. Likert scales may be subject to distortion from several causes. Respondents may avoid using extreme response categories (*central tendency bias*); agree with statements as presented (*acquiescence bias*); or try to portray themselves or their organisation in a more favourable light (*social desirability bias*). Designing a scale with balanced keying (an equal number of positive and negative statements) can obviate the problem of acquiescence bias, since acquiescence on positively keyed items will balance acquiescence on negatively keyed items, but central tendency and social desirability are somewhat more problematic. http://en.wikipedia.org/wiki/Likert_scale#Sample_question_presented_using_a_five-point_Likert_ Accessed 16th July, 2009

The two documents along with the full questionnaire were translated into the most widely spoken local language in the Lusaka province (the Chinyanja language- See Appendix) for ease of communication with participants who were not proficient in the English language. An additional exit questionnaire with semi-structured questions open-ended questions (see Section---- Qualitative data analysis) was developed for in-depth interviewing (Appendix 8) of participants at the conclusion of the main Intervention. This formed the basis of gleaning qualitative data particularly from participants in the Life Transformation Seminars (LTS).

4.8 DATA ANALYSIS

As stated earlier, analysis of the data was carried out in two stages. Firstly, *cross tabulations* were used to examine relationship between safer sexual behaviour and socio-economic variables. For the statistical analysis, *chi-square* tests of independence were conducted at the bivariate level, and the differences were determined at $P < 0.01$ and $P < 0.05$ significant level. Secondly, major predictors were carried out with the help of logistic regression analysis.

The results of the logistic regression models were converted into odds ratios, which represented the effect of a one-unit change in the explanatory variable on the indicator of experiencing safer sexual practices and abstaining from sex. Odds ratios larger than one indicate a greater likelihood of experiencing safer sexual practices and abstaining from sex than for the reference category; odds ratios smaller than one indicate a smaller likelihood compared to the reference category.

Data were analysed using SPSS 9.00 for logistic and Chi-square tests. Cross tabulations were carried out to find out the shape of the relationship between

independent variables and outcomes. Chi-square test was done in order to find out whether the observed relationships between independent variables and outcomes occurred by chance or whether they were statistically significant. Significance was tested by means of 95 % ($P < 0.05$) and 99 % ($P < 0.01$) of confidence intervals. Selected dependent variables include being abstinent before marriage, being maritally faithful, lifestyle, longevity, increased levels of hope, happiness and productivity, and decreased likelihood of spreading the virus.

4.9 QUALITATIVE DATA ANALYSIS

A thematic analysis procedure was used to analyse the qualitative data using *Atlas.ti* software. Thematic analysis is ordinarily used to identify and analyse themes and patterns within the data (Braun & Clarke, 2006). This analysis procedure is compatible for use with mixed methods research and particularly with a generic qualitative inquiry (Percy & Kostere, 2008).

The qualitative data were gathered through the use of semi-structured questionnaires with open-ended questions (Bernard, 1998 rev 2013). The researcher read and re-read each participant's responses and highlighted any words, sentences, phrases, or paragraphs that appeared meaningful and related to the research question (Percy & Kostere, 2008). The *Atlas.ti Version 5* qualitative analysis software was employed to generate patterns and themes from the responses of participants.

The patterns and themes were pulled from the coded data and the meaningful groups into which the coded data had been divided. Some direct quotes are used to provide examples of and explain the themes that have emerged from the coded data (Bryne, 2001; Percy & Kostere, 2008). The different themes were carefully reviewed

in order to make sure that they reflect the research question (Braun & Clarke, 2006). Further reflection on the qualitative data was guided by the use of the grounded theory (Strauss and Corbin, 1990 & 1998) as a conceptual framework and lens for gleaning applicable insights from respondents to complement the sub themes generated through the software.

4.10 IMPLEMENTATION OF THE MAIN INTERVENTION

4.10.1 Life Transformation Seminars (LTS)

The main intervention for the study was conducted through the convening of 24 Life Transformation sessions using the Life Transformation Seminar (LTS) curriculum compiled for this purpose. Each session ran for approximately 1 hour. Invariably participants stayed on for longer as the sessions took root and as they got more acquainted with each other.

The material content for the LTS was compiled from the Bible incorporating key tenets of the Christian faith from a spiritual formation perspective, as is common in practical teachings of many Zambian Pentecostal Churches. Although the participants varied in terms of religious affiliation (See background characteristics, Section 5.3.1.1), the Pentecostal norm was chosen as a distinctive norm and pattern of delivery as it is the environment in which the HIV initiatives under exploration, grew.

The biblical material content was supplemented by motivational anecdotes from publications of 5 Christian motivational teachers (Maxwell 2000; Munroe 2012; Shwartz 2007; Tracey 2010; Maldanado 2011).

Using predominantly biblical content was a purposive step to test adequately the hypothesis central to the study, that attendance to such a congregation-based programme alters the sexual behaviour of the participants. In particular, no specific mention of HIV was included so that LTS participants would be exposed to content that generally is, as much as possible, close to the norm in Church services in Pentecostal congregations. Surprisingly, HIV related matters would still emerge from time to time during discussions.

The LTS was designed to run over a period of 12 weeks (approximately 3 months) starting shortly after the first initial survey was administered, so that completion of the LTS training would coincide later with the timing for implementation of the follow-up survey measure at the conclusion of the applicable modules.

A summarised outline of the material is included in Appendix 11 to demonstrate a possible replicable model for congregations. There were 9 topic divided into 3 modules sets (I, II and III) each containing 3 topics and each topic delivered in two part tiers, as the sessions were conducted twice weekly for the applicable period. After each module set, the intervening week was structured as an 'open' session, meeting once only, in a double session format of up two hours maximum (on a Friday) where the participants gave feed back on the previous week's lessons covered and shared personal stories (testimonies). Thus, there were a total of 3 open sessions delivered in weeks 4, 8 and 12, respectively.

The format adopted for all the sessions was a basic interactive approach normally utilised in church Life groups, where a leader introduces the topic of the day, after formalities of salutations and opening prayer, brief worship and song time, then the teaching and later a semi-formal but practically informal question and answer time.

However, their order remains flexible enough for participants to interject at any point and ask a question or seek clarification. The song and worship time also comes again at the end of the session. Miller and Yamamori (2007) posited, "The engine of Pentecostalism is its worship… the heart of Pentecostalism is its music."

The base line survey done at the commencement of the LTS (for 122 enrolled) was administered simultaneously (by assigned research assistants) with the base line survey undertaken (for 135 enrolled in the control group, not included in the LTS) and necessarily located elsewhere geographically in the Makeni community, to forestall data contamination. The same applied at the close of the intervention period where the follow-up measure was carried out on 102 LTS participants on one hand, who completed the training and 114 participants in the control group, on the other hand.

4.10.2 Focus Group Discussions (FGD)

Since the targeted group for the FGDs were the existing support group of the COH and they meet monthly, a variation was made for them to meet bi-weekly during the period of data collection for the study. A total of 6 sessions were held with an average attendance 85 of the nearly 100 registered members.

The spectrum of discussions as per FDG guidelines were directly and topically related to HIV (see Appendix 7 and 8) and covered subjects of health, congregation-based programme perspectives and sexual behaviour.

4.10.3 Ethical Considerations

Weis and Fine (2000) called for researchers to take into account "ethical considerations involving [their] roles as insiders/outsiders to the participants; assessing issues that [they] may be fearful of disclosing," adding that researchers must also consider "establishing supportive, respectful relationships without stereotyping and using labels that participants do not embrace." In this respect Weis and Fine (2000) insisted on the need to acknowledge the persons "whose voices will be represented in [the] final study; and writing ourselves into the study by reflecting on who we are and the people we study."

Hatch (2002) stated, "we need to be sensitive to vulnerable populations, imbalanced power relations, and placing participants at risk." Creswell (2012) discussed particularly ethical issues in qualitative research (which in the estimation of this study would still apply also to the quantitative) pointing out that they can be described "as occurring prior to conducting the study, at the beginning of the study, during data collection, in data analysis, in reporting the data, and in publishing a study." In addition to the steps taken and described in this section, this study adopted Creswell's guideline as presented in Appendix 13.

Prior to conducting a study, permission was secured from the Bio-medical Research Ethics committee of the University of Zambia. The full research proposal inclusive of the questionnaires and standard consent forms (See Appendix 1-9) were duly submitted. Following approval, the training of 10 research assistants took into account all salient ethical requirements highlighted herein, for the administering the survey instruments the during data collection stage. The standard has been adhered to through out every stage of the research.

The study also conformed fully to the requirements of the Oxford Centre for Mission Studies (OCMS) Ethics Review process as per OCMS Ethics Review guidelines.

4.11 ADDRESSING THE METHODOLOGICAL CHALLENGES

One of the key challenges facing a mixed method approach like the one chosen for this study was addressed satisfactorily. It is the concurrent collection of data (quantitative and qualitative). The researcher followed the guidance of Creswell and Plano-Clark (2011) who proposed putting together a research team of persons with requisite skills in each methodological discipline.

Firstly, the researcher anticipated the said challenges, therefore early consultations and feed back from the two supervisors (Dr Chris Sugden and Professor Emil Chadran) was an important source of guidance. Professor Chandran is a statistician and has written a textbook on quantitative research methods. Thus, guidance and input was assured from the time of design of the research tools. In the early stages as well as later, there was assistance offered by the researcher's house tutor, Mr Brian Woolnough, a former science lecturer at the Oxford University with immense expertise in empirical data collection and management.

Secondly, based on previous collaborations on similar tasks, and upon recommendation from the study supervisors, the researcher elected to work with Dr Prashant Kusanthan, a lecturer and head of the Gender Department at the University of Zambia and a quantitative expert who perused the respective designed data collection tools and made suggestions for improvement. Similarly, for the qualitative, a lecturer in that field at the University of Zambia, Mr. Nkenda Sachingongu gave

input on the qualitative side of the research work. Later, Dr Kusanthan assisted to co-train the 10 research assistants (RAs) enlisted by the researcher to assist with data collection. During the entire data collection phase, the collaboration continued and helped to address emerging challenges.

For instance, at one point in the late stages of the data collection, two raw data sets were observed as bearing some inconsistent entries and would probably have been subsequently lodged with errors in the computer. However, the pre-sorting verification process brought it to light. The research team including the two RAs returned to site and re-identified the mismatched informants.

Another challenge that emerged and was adequately resolved very early in the research project was the visibility of the researcher, being a fairly prominent religious leader and then Chairperson of the National AIDS Council. The concern of a potentially 'over-bearing' Principal Investigator on respondents and the possibility of bias was a reality requiring attention.

The researcher utilised the opportunity of the availability of 10 neutral research assistants who were trained adequately to administer the research tools. The researcher therefore, minimised visibility, particularly to the informants and only handled aspects of the research where his person, ethically, would not influence bias.

4.12 SUMMARY OF CHAPTER 4

This chapter has discussed the research methodology that was employed in the study, which is that of a quasi-experimental research design. This is because the purpose was to compare the results of a treatment and control group with respect to the scores received on a post-intervention assessment. The chapter included information on the data collection process as well as proposed statistical analyses, which include cross

tabulations to examine the relationship between safer sexual behaviour and socio-economic variables as well as chi-square tests of independence at the bivariate level.

Major predictors were carried out with the help of logistic regression analysis. The research design has emerged into a mixed method design following the convergent parallel design as a prototype. The proposed research questions, the population and sample size were also discussed.

The chapter notes the challenges facing a convenience sampling approach such as the one used for this study and enumerates the steps that were taken to minimise selection bias. The chapter has also provided details of the main intervention implementation and also narrated the ethical considerations as well the methodological challenges and how they were resolved. The succeeding chapters present the results of the study, including the data and their analysis. Further chapters will provide full discussion of the results, present the drawn conclusions, and some recommendations for future research.

CHAPTER 5: RESULTS

This chapter enumerates both the quantitative and qualitative results that will be followed by respective analyses and discussion in the next two chapters.

5.1 RESTATEMENT OF RESEARCH FOCUS AND CONTEXT

This study set out to investigate (1) whether and how interventions affect impacts in congregation-based HIV/AIDS programmes, and (2) whether and how abstinence and marital fidelity function within the larger picture of overall strategies to combat AIDS. This was achieved by examining the community outreach work of the Circle of Hope Family Care Centre, a congregation-based HIV/AIDS support group initiative undertaken by the Northmead Assembly of God Church in Lusaka, Zambia.

5.2 RESTATEMENT OF RESEARCH QUESTIONS

To establish how interventions, affect impacts in congregation-based HIV/AIDS programmes, the study was framed around the following research questions:

MAIN QUESTION: Is a person's sexual behaviour influenced by their attitude and behaviour towards God? SUBSIDIARY QUESTIONS: i) What are the factors, which affect a person's sexual lifestyle? ii) Does attendance at the church's HIV/AIDS programmes cause a change of behaviour in a person's sexual relationships?

Pursuant to the execution of the chosen experimental design of the study (involving an intervention group and a control group) an intensive set of Life Transformation Seminars (LTS) composed of fully faith-based biblical content (See

Appendix 11) were implemented as the main intervention, with a repeat measure administered after three months. Concurrently, Focus Group Discussions (FGDs) with the COH support group were conducted.

5.3 EXPLANATION OF RESULTS

Key Findings:

*The results of the logistic regression analysis (below) show that those that participated in the Life Transformation faith-based Seminars were **4.1 times more likely** to report having adopted new behaviour or modified old behaviour, specifically to live positively than those who did not attend the faith based seminar. Similarly, those that participated in the Life Transformation faith-based Seminars were **2.3 times more likely** than those who did not participate in the seminars to report having adopted safer sexual practices. The results further reveal that those that participated in the Life Transformation seminars were more likely to report abstinence from sex than those who did not attend the seminars.*

5.3.1 The Life Transformation Seminar (LTS) Intervention

5.3.1.1 Background Characteristics of Respondents

Table 9 presents results of the findings at Baseline and Follow-up stages incorporating both the intervention and control groups, respectively. The analysed data indicates that during the baseline survey there were 62% female and 38% male by gender in the intervention group and the figures remained the same in the follow-up survey. In the control group during the baseline there were 62 and 38% of female and males, respectively. 60 and 39% females and males were in the control-group during the follow-up.

5.3.1.2 Age and Education level

The age of respondents ranged from 29 to over 45 years. There were more respondents with senior secondary school in the intervention and control groups. During the baseline and follow-up (Intervention group) there were 33% of respondents with senior secondary education level, respectively. In the baseline and follow-up (Control group) there were 34% and 30% respondents with senior education, respectively.

5.3.1.3 Marital status

Three categories of marital status were considered in this study: single, currently married and widowed. Currently married had more respondents in the intervention and control-groups as presented in Table 4.1.

5.3.1.4 Working status

Two categories were studied. These were 'not working' and 'currently working'. The 'not working' category have more respondents in the intervention (baseline = 57%, follow-up = 55%) and control group (baseline = 51%. follow-up = 54%).

5.3.1.5 Religious affiliation

Respondents from three religions groups were studied: Pentecostal, Protestant and others. There were more respondents from the Protestant grouping in the intervention (Baseline = 37%; Follow-up = 40%) and control (Baseline = 38%; Follow-up = 40%) groups.

Table 9: Background Characteristics of Respondents

Characteristics	Intervention-Group		Control – Group	
	Base-line	Follow-up	Base-line	Follow-up
Sex				
Male	37.9%	37.5%	38.0%	38.6%
Female	62.1%	62.5%	61.8%	60.0%
Age				
< 29	16.5%	13.7%	20.6%	20.1%
30-34	20.3%	20.6%	22.6%	22.9%
35-39	25.8%	24.5%	20.2%	19.3%
40-45	20.9%	21.6%	20.6%	19.3%
45+	16.5%	19.6%	16.0%	17.4%
Educational level				
No schooling	5.5%	5.9%	7.2%	5.7%
Junior primary	4.9%	5.9%	4.9%	4.3%
Senior primary	29.1%	30.2%	29.1%	30.0%
Junior secondary	27.5%	25.5%	23.7%	29.7%
Senior secondary +	33.0%	32.5%	34.0%	30.3%
Marital status				
Single	18.1%	17.7%	14.9%	12.9%
Currently married	48.4%	50.0%	49.2%	48.6%
Widowed	33.5%	32.3%	34.5%	35.7%
Working status				
Not working	56.6%	55.0%	51.0%	54.3%
Currently working	43.4%	45.0%	49.0%	45.7%
Religion				
Pentecostal	25.8%	29.4%	30.6%	30.6%
Protestant	36.8%	40.2%	37.5%	40.0%
Others	28.6%	29.4%	27.4%	24.3%
N	**122**	**102**	**135**	**114**

5.3.1.6 Household status by educational level of respondents

Table 4.2 presents disaggregation of household status by level of education and age. Household assets were categorised as poor, middle or rich. Respondents from the middle household asset level had the largest number of No schooling (50%), Junior primary (40%), Senior primary (46%) and Senior secondary (54%) as presented in Table 4.2. It was followed by the Poor and lastly, the Rich household assets.

Table 10: Household status by educational level of respondents

	Educational level			
	No schooling	**Junior primary**	**Senior primary**	**Senior secondary+**
Household assets				
Poor	35.7	33.3	31.5	23.7
Middle	50.0	40.0	45.7	53.9
Rich	14.3	26.7	22.8	22.4

5.3.1.7 Household status by age of respondents

Household assets by age of respondents are presented in Table 4.3. Results indicate that the Middle class with 20-30 years had 51% of respondents followed by 40 years and above (47%) and 31-39 years (43%). There were more respondents in the Middle 20-30 years whilst the Poor and Rich had more respondents in the 20-30 years and 31-39 years, respectively.

Table 11: Household status by age of respondents

	AGE		
	20-30	31-39	40+
Household assets			
Poor	36.4	27.7	27.1
Middle	50.9	42.9	46.8
Rich	12.7	29.4	26.1

5.3.1.8 Percentage of respondents who have ever taken alcohol

Percentage of respondents who have ever taken alcohol is presented in Figure 1. At baseline in the intervention group, 24% of the respondents had not taken alcohol while 76% of the respondents reported having taken alcohol. In the intervention group during the follow-up, 72% of the respondents reported not having taken alcohol while 28% had take alcohol. In the Control group at baseline, 31% reported that they had not taken alcohol. 69% of the respondents at baseline reported having

taken alcohol. During the follow-up 43% of the repondents reported that they had not taken alcohol. There was an increase in the percentage of respondents who reported not having taken alcohol. 57% of the respondents in the follow up (Control-group) reported that they had ever taken alcohol. There was a reduction in the percentage of respondents during the Follow-up from 69% to 57%.

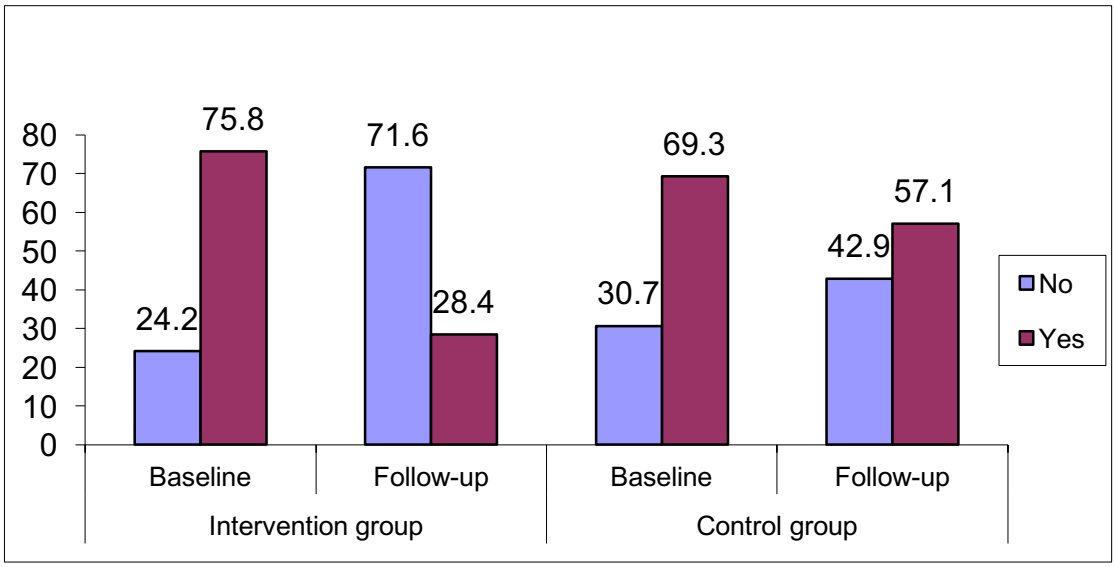

Figure 6: Percentage of respondents who have ever taken alcohol

5.3.1.9 Percentage of respondents who reported taking drugs

Figure 2 show the percentage of respondents who reported taking drugs. In the intervention group during the baseline, 86% reported having been taken drugs while at follow-up all the respondents reported not taking drugs. In the Control-group, at baseline 79% of the respondents reported taking drugs while at the follow-up 82% reported taking drugs. 18% of the respondents in the Control-group (Follow-up) reported not taking drugs. The intervention worked 100 % in the intervention group.

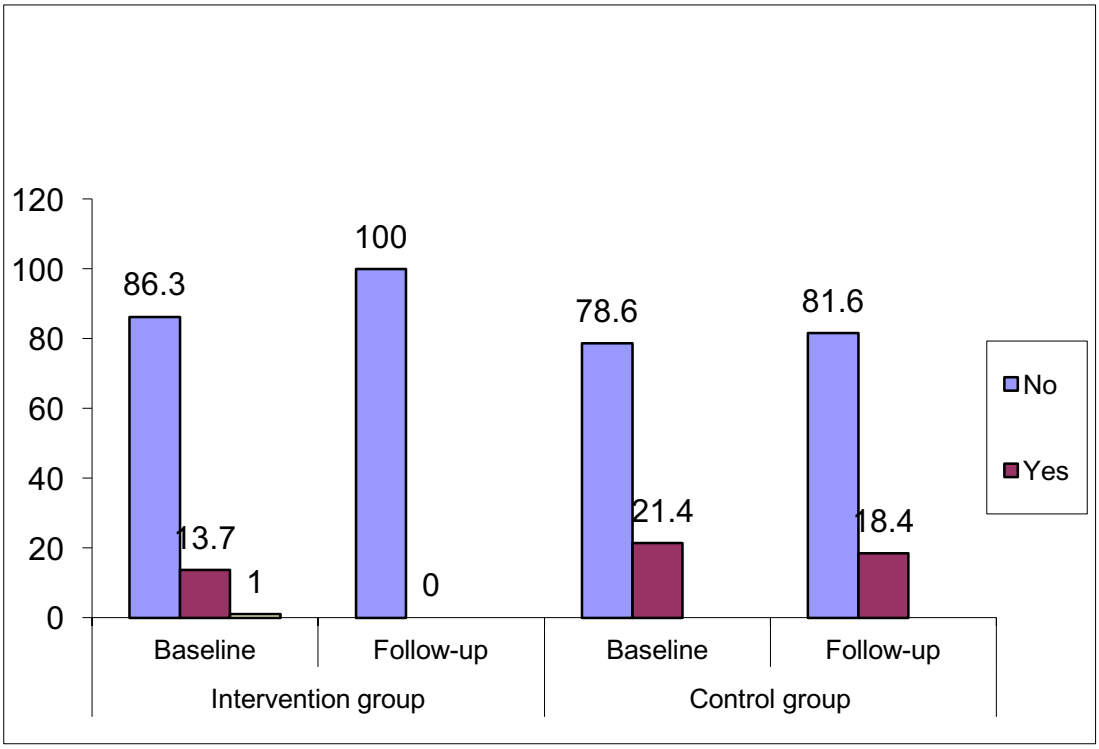

Figure 7: Percentage of respondents who reported taking drugs

5.3.1.10 Percentage of respondents who reported drinking in a bar

Results of percentage of respondents who reported drinking in a bar are presented in Figure 3. Results indicate that 26% of the respondents reported drinking in a bar at baseline in the intervention group. During the follow-up in the intervention group there was a reduction in the percentage of respondents reporting drinking a bar to 3%. In the Control Group 24% of the respondents at baseline reported drinking in a bar while during the follow-up survey 19% of the respondents reported drinking in a bar. Results indicate that the intervention was effective in reducing the percentage of respondents who reported drinking in a bar.

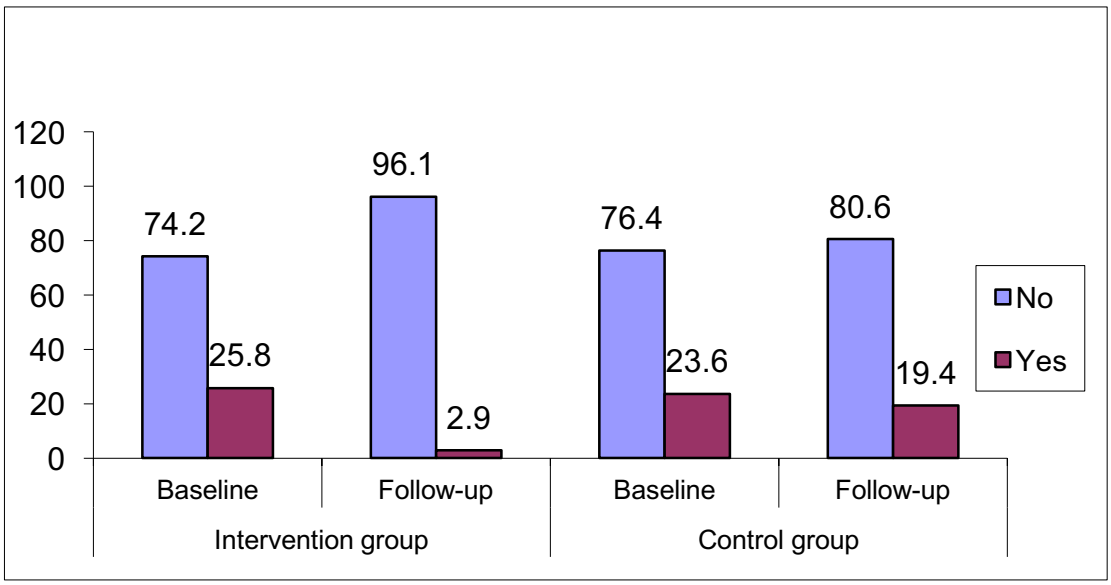

Figure 8: Percentage of respondents who reported drinking in a bar

5.3.1.11 Percentage of respondents who reported smoking cigarettes

Percentage of respondents who reported smoking cigarettes at baseline in the intervention group was 8%. During the follow-up 100% of the respondents reported not smoking cigarettes. In the Control Group the percentage of respondents smoking cigarette increased from 7% (Baseline) to 12% (Follow-up). Results presented in Figure 4 indicate that the intervention was effective in the Intervention Group.

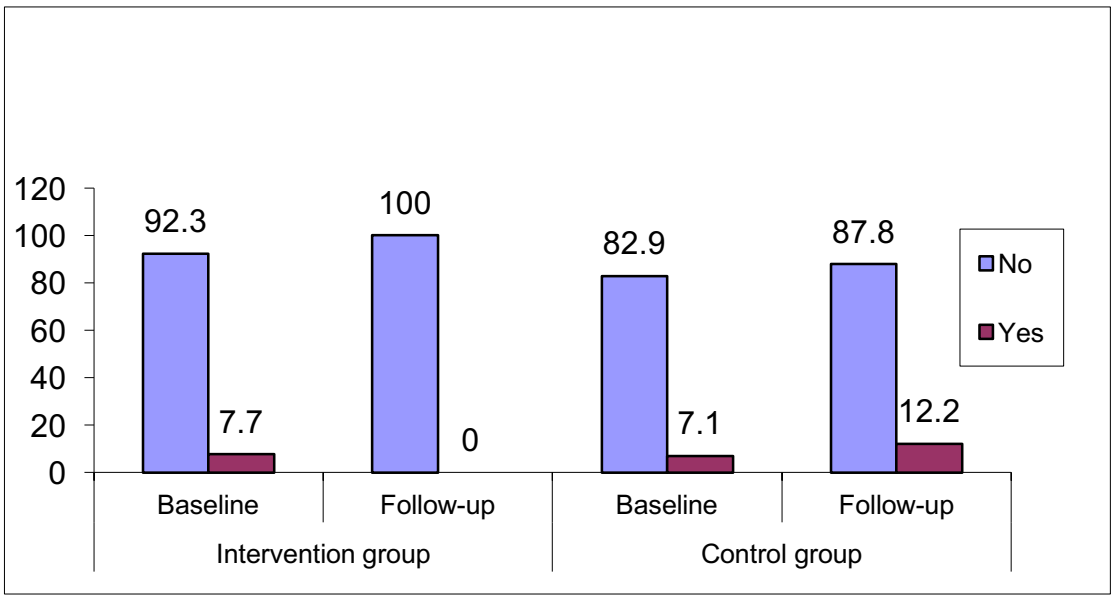

Figure 9: Percentage of respondents who reported smoking cigarettes

Table 12: Further characteristics of Respondents

Characteristics	**Intervention-Group**		**Control – Group**	
	Base-line	Follow-up	Base-line	Follow-up
Ever been born again				
No	46.2%	11.8%	51.4%	40.5%
Yes	53.8%	88.2%	48.6%	59.5%
Have been baptized				
No	62.1%	13.7%	60.7%	48.8%
Yes	37.9%	86.3%	39.3%	51.2
Attended church services during the last three months	4.9%	0.0	11.4%	6.7
Never	34.6%	8.8%	22.1%	8.5
At least one	10.4%	6.9%	32.1%	36.5
Two times	50.0%	81.4%	34.3%	48.3
More than two times				
Attended prayer meetings during the last three months	17.6%	13.7%	12.1%	11.6
Never	31.9%	7.8%	25.6%	10.8
At least one	3.8%	24.5%	22.1%	28.5
Two times	44.5%	52.0%	40.3%	49.1
More than two times				
How often prayed to God during the last four weeks				
Everyday	52.7%	72.5%	42.9%	41.8%
At least once a week	14.8%	21.6%	16.4%	20.9%
Less than once a week	14.8%	1.0%	15.7%	27.9%
Not at all	15.9%	2.9%	17.9%	9.4%

How often read the bible for the last four weeks				
Everyday	24.2%	49.0%	17.1%	13.1%
At least once a week	35.7%	26.5%	29.3%	26.6%
Less than once a week	26.4%	14.7%	28.6%	36.8%
Not at all	12.1%	7.8%	25.0%	23.5%
Attended congregation-based seminar during the last three months				
No	90.1%	17.6%	91.4%	85.5%
Yes	9.9%	82.4%	8.6%	14.5%

5.3.1.12 Percentage of respondents who think HIV/AIDS is punishment from God for promiscuous people

Percentage of respondents who think HIV/AIDS is punishment from God (Figure 10) for promiscuous people in the Intervention Group at baseline and follow-up were 47% and 8%, respectively. The Intervention leads to higher reduction in the percentage of respondents (92%) who think HIV/AIDS is punishment from God for promiscuous people. In the Control-group the percentage of respondents who think HIV/AIDS is punishment from God for promiscuous people reduced from 43% (Baseline) to 31% (Follow-up).

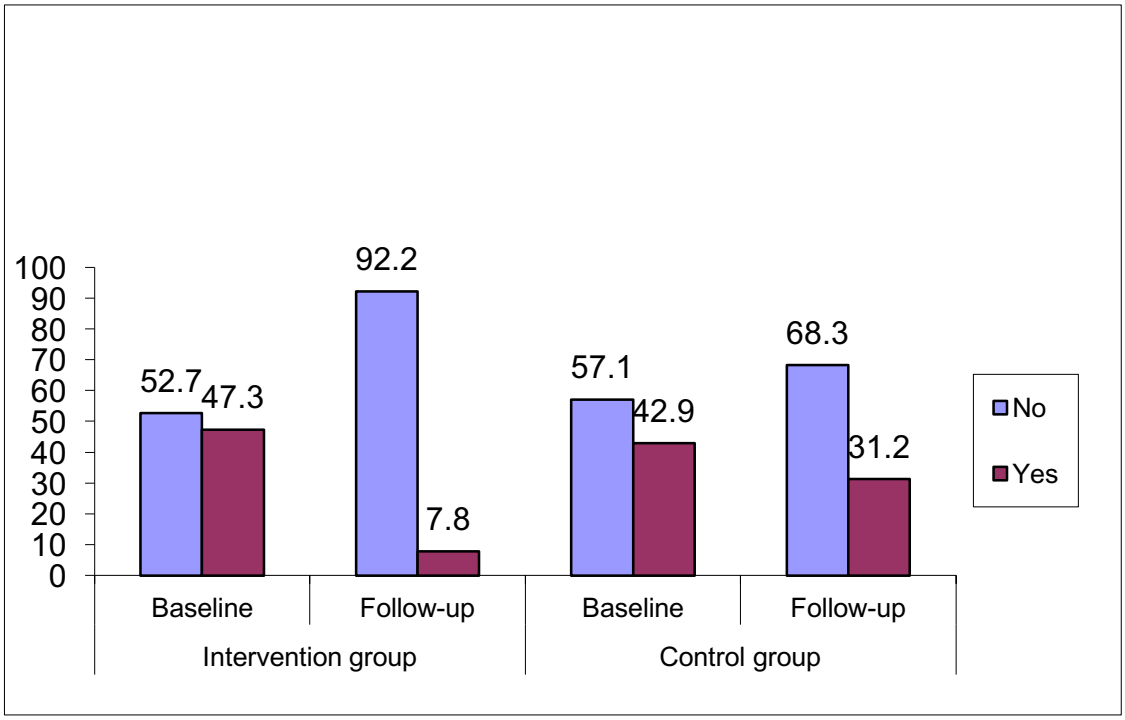

Figure 10: Percentage of respondents who think HIV/AIDS is punishment from God for promiscuous people

5.3.1.13 Percentage of respondents who think AIDS is just one way of dying, it cannot be avoided

Figure 11 shows percentage of respondents who thought AIDS is just one way of dying; it cannot be avoided. In the Intervention Group the percentage reduced from 32% (Baseline) to 10% (Follow-up). The percentage of respondents who reported that AIDS is not just one way of dying in the Intervention Group increased from 68% (Baseline) to 90% (Follow-up). This indicates that the intervention was effective in influencing a change in attitude to the Intervention Group. In the Control-group the percentage of respondents who think AIDS is just one way of dying, it cannot be avoided increased from 25% (Baseline) to 39% (Follow-up).

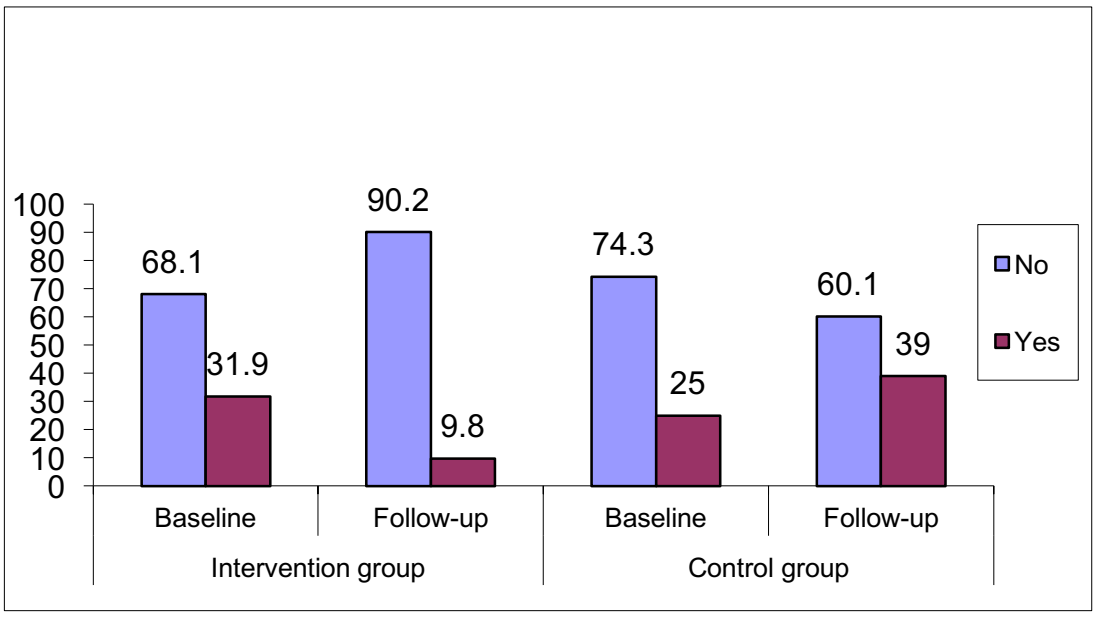

Figure 11: Percentage of respondents who think AIDS is just one way of dying, it cannot be avoided

5.3.1.14 Percentage of respondents who reported number of partners they had sex with in the past three months

Results of percentage of respondents who reported number of partners they had sex with in the past three months are presented in Figure 12, below. In the Intervention Group at baseline, 34% of the respondents reported having sex with one partner. 21% of the respondents reported not having sexual partners in the last three months. During the Follow-up in the Intervention Group, 64% of the respondents reported not having any sex partner in the past three months compared to 21% during the baseline. After the intervention there was a reduction in the number of partners with whom respondents reported that they had sex in the last three months. In the Control-group there was a small change for example, 37% (Baseline) and 39% (Follow-up) of respondents reported having one sex partner in the last three months.

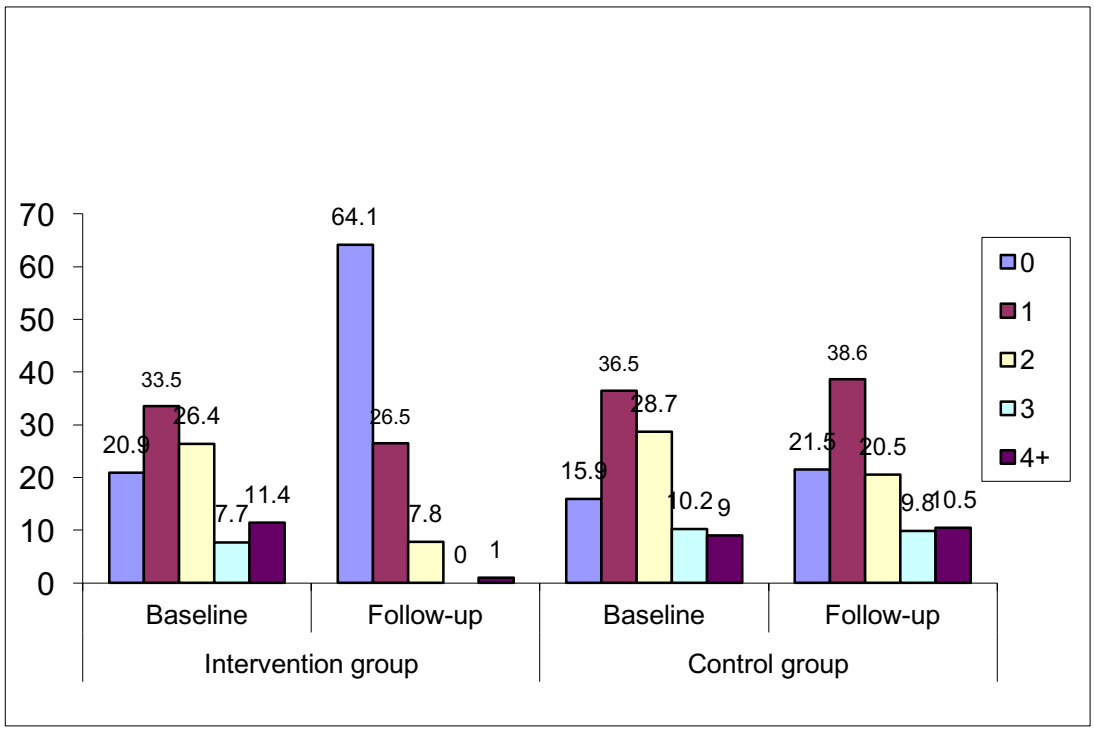

Figure 12: Percentage of respondents who reported number of partners they had sex with in the past three months

5.3.1.15 Percentage of respondents who reported having had sex with a boy/girl friend during the last three months

Percentage of respondents who reported having had sex with a boy/girl friend during the last three months (Figure 13) was 65% (Baseline) and 10% (Follow-up) in the Intervention Group. Respondents reporting not having had sex with boy/girl friend increased from 33% (Baseline) to 93% (Follow-up). In the Control-group, percentage of respondents who reported having had sex with a boy/girl friend during the last three months was 70% (Baseline) and 65% (Follow-up). Results presented in Figure 8 reveals that the intervention was effective in reducing the percentage of respondents who reported having had sex with a boy/girl friend during the last three months.

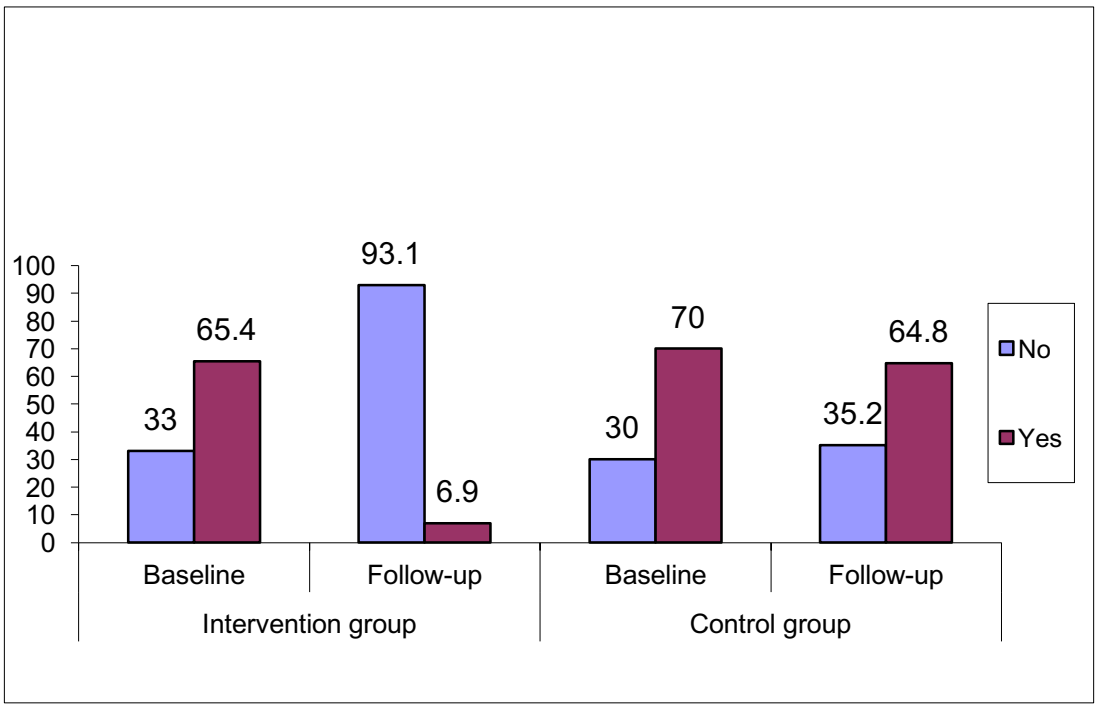

Figure 13: Percentage of respondents who reported having had sex with a boy/girl friend during the last three months

5.3.1.16 Percentage of respondents who reported number of times they had sex with their boy/girl friend in the last three months

In the Intervention Group the percentage of respondents who reported zero number of times they had sex with their boy/girl friend in the last three months (Figure 14) increased from 32% (Baseline) to 93% (Follow-up). There was also a decrease in the percentage of respondents who reported number of times they had sex with their boy/girl friend in the last three months as presented in Figure 9. In the Control-group, there were smaller changes in the percentage of respondents who reported diminished number of times they had sex with their boy/girl friend in the last three months.

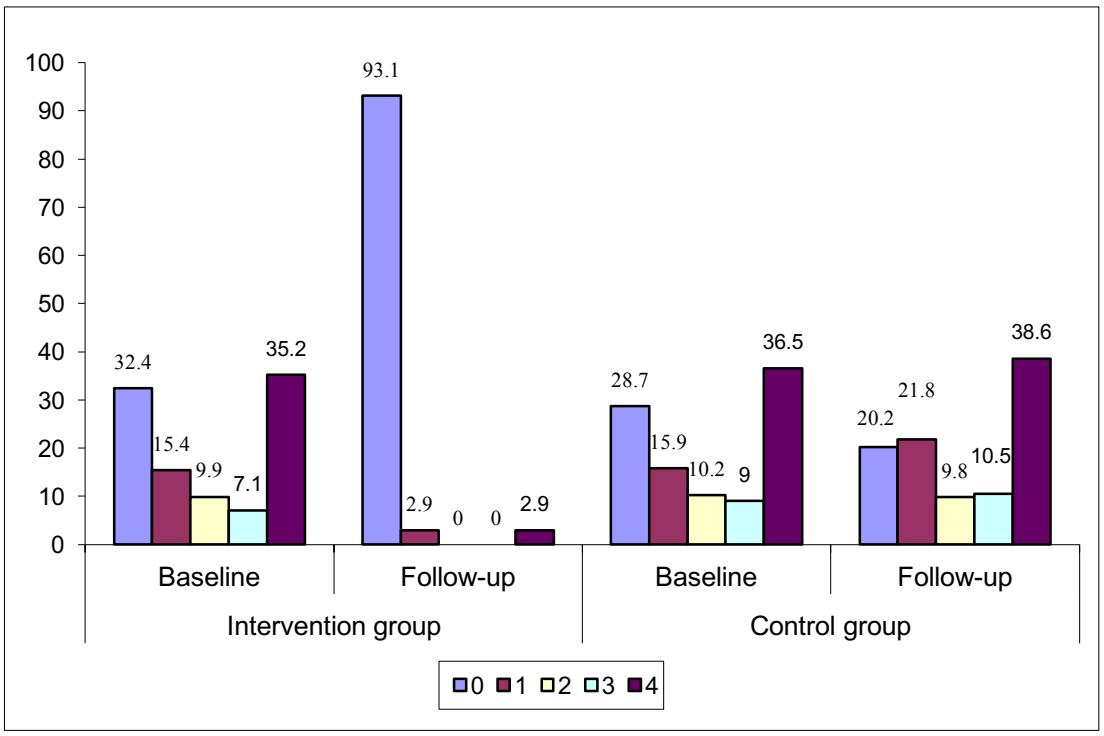

Figure 14: Percentage of respondents who reported number of times they had sex with their boy/girl friend in the last three months

5.3.1.17 Percentage of respondents who reported how often they use a condom with their boy/girl friend

The percentage of respondents who reported how often they use a condom with their boy/girl friend is shown in Figure 15. 32% (Baseline) and 93% (Follow-up) in the Intervention Group shows an increase in the percentage of respondents who always use a condom with their boy/girl friend. The percentage of respondents who use the condom most of the time, half the time, sometimes and never reduced from 23%, 2%, 6% and 28% (Baseline) to 4%, 0%, 0% and 3% (Follow-up) in the Intervention Group. Results show that the intervention was effective in changing the mind-set of respondents towards condom use. In the Control-group, there were changes also in condom use. 27%, 30%, 4%, 10% and 7% of the respondents at Baseline reported

that they Always, Most of the time, Half of the time, Sometime and Never use a condom with their boy/girl friend, respectively. During the Follow-up, 18%, 11%, 30%, 38% and 4% of the respondents reported that they Always, Most of the time, Half of the time, Sometime and Never use a condom with their boy/girl friend, respectively.

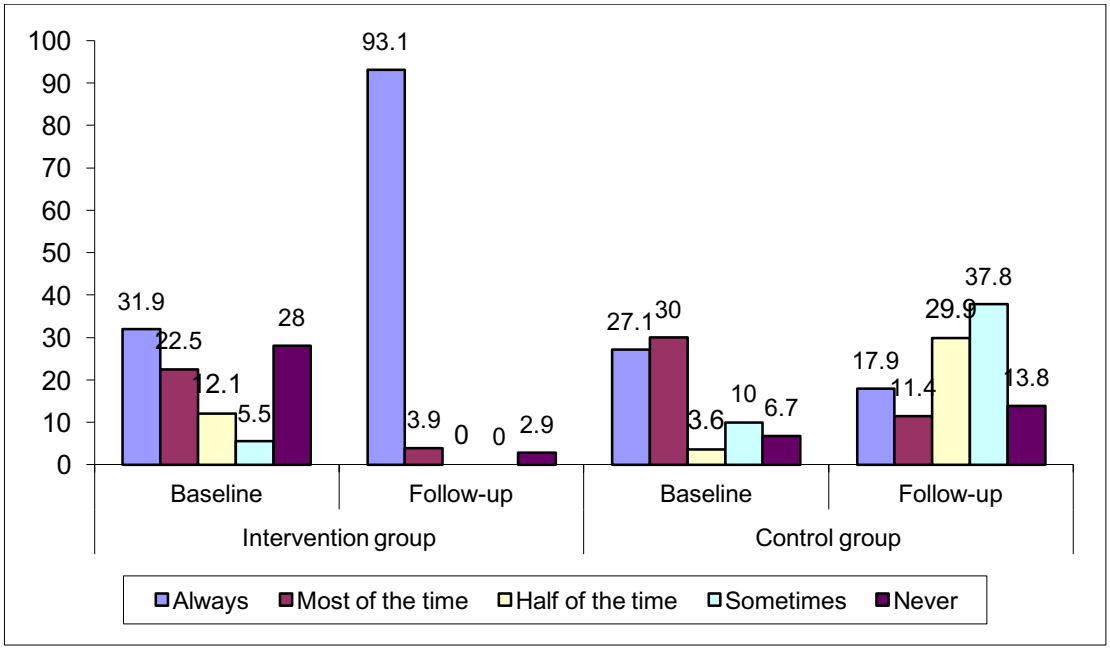

Figure 15: Percentage of respondents who reported how often they use a condom with their boy/girl friend

5.3.1.18 Percentage of respondents who reported having had sex outside of marriage during the last three months

The percentage of respondents who reported having had sex outside of marriage during the last three months is presented in Figure 16. There was a reduction in the percentage of respondents who reported having had sex outside of marriage during the last three months from 63% (baseline) to 3% (Follow-up) in the Intervention

group. This indicates that the intervention was effective in reducing the percentage of respondents having sex outside marriage in the last three months. In the Control-group as presented in Figure 16 shows insignificant change in the Follow-up.

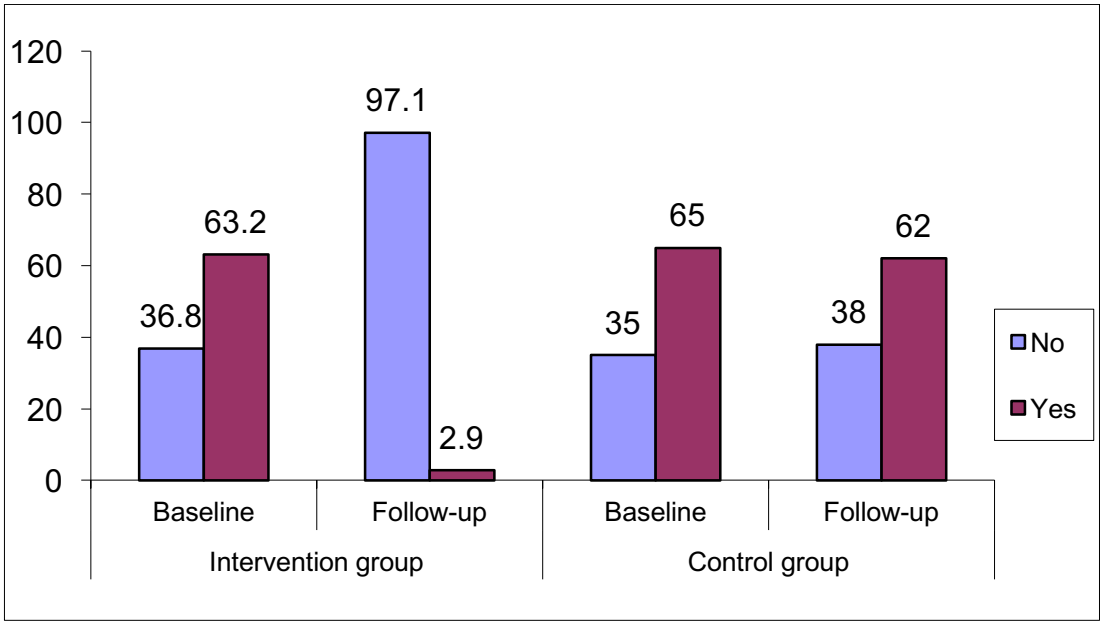

Figure 16: Percentage of respondents who reported having had sex outside of marriage during the last three months

5.3.1.19 Percentage of respondents who reported number of people with whom they had had sex outside marriage in the past three months

The percentage of respondents who reported the number of people with whom they had had sex outside marriage in the past three months are presented in Figure 17. The percentage of respendents who reported the number of people with whom they had had sex outside marriage reduced from 43% (1), 3% (2), 2% (3) and 6%(4+) (Baseline) to 7% (1), 3% (2), 0% (3) and 0% (4+), respectively. On the other hand, the number of respondents who did not have any sex outside marriage also increased

from 37% (Baseline) to 90% (Follow-up). Results shows that the intervention was effective in changing the attitude of respondents to avoiding sex outside marriage. Results as presented in Figure 17 shows that they were smaller changes in the Control-group.

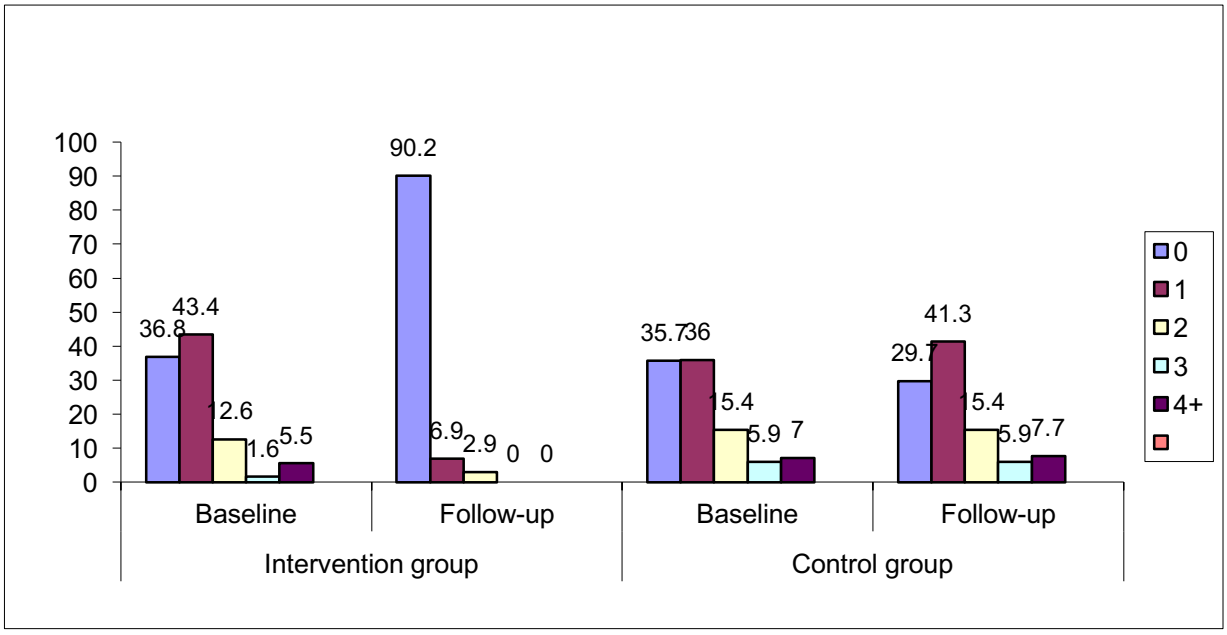

Figure 17: Percentage of respondents who reported number of people with whom they had had sex outside marriage in the past three months

5.3.1.20 Percentage of respondents who reported number of concurrent partners they had sex with in the last three months

The percentage of respondents who reported the number of concurrent partners with whom they had sex with in the last three months is presented in Figure 18. The percentage of respondents without concurrent sex partners increased from 35% (Baseline) to 79% (Follow-up). There was also reduction in the percentages of respondents reporting the number of concurrent sex partners from 40% (1), 12% (2), 7% (3) and 7% (4+) (Baseline) to 18% (1), 3% (2), 0% (3) and 0% (4+) (Follow-up),

respectively. There were slightly small changes in the Control-group between the Baseline and Follow-up as shown in Figure 18.

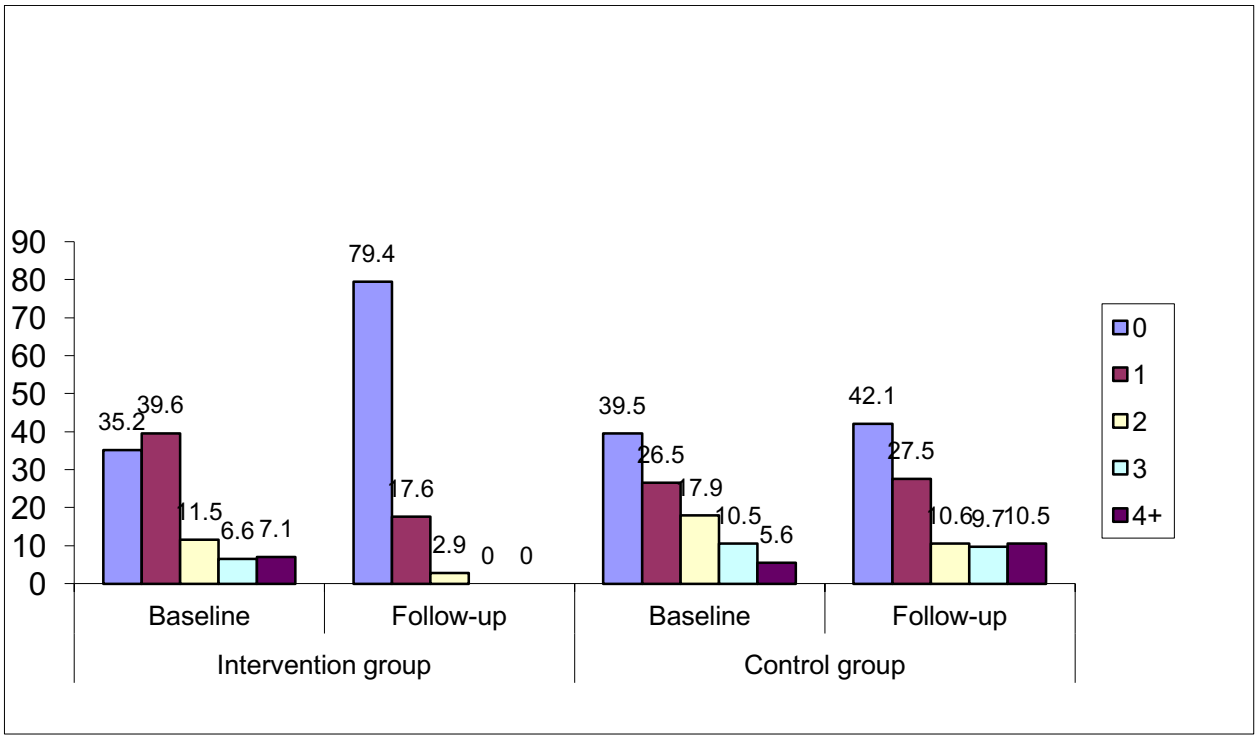

Figure 18: Percentage of respondents who reported number of concurrent partners they had sex with in the last three months

5.3.1.21 Percentage of respondents who reported having had concurrent relationships and who reported having adopted new behaviour in the last three months

Percentage of respondents who reported having had concurrent relationship in the last three months as presented in Table 12 were from the Rich (27%) (Household assets), age (31-39) and Primary (educational level) in the intervention follow-up

whilst in the Control follow-up were from the Poor (88%), age (40+) and Primary (educational level). Percentage of respondents who reported having adopted new behaviour in the last three months was Rich (73%) (Household assets), age (31-39) and Secondary (educational level) in the Intervention follow-up. In the control follow-up, the Middle (household assets), age (40+) and Secondary (educational level) of respondents reported having adopted new behaviour in the last three months.

Table 11: Percentage of respondents who reported having had concurrent relationships and who reported having adopted new behaviour in the last three months

Characteristics	% Who reported having had concurrent relationships in the last three months		% Who reported having adopted new behaviour in the last three months	
	Intervention follow-up	Control follow-up	Intervention follow-up	Control follow-up
Household assets				
Poor	22.2%	88.0%	72.2%	14.0%
Middle	17.2%	81.8%	55.2%	36.4%
Rich	26.9%	83.7%	73.1%	28.6%
Age				
20-30	16.7%	82.1%	61.1%	25.6%
31-39	23.8%	82.4%	66.7%	27.5%
40+	19.0%	86.0%	59.5%	30.0%
Educational level				
Primary	22.4%	85.7%	61.2%	21.4%
Secondary	18.9%	82.1%	64.2%	32.1%

5.3.1.22 Percentage of respondents who reported having had sex outside of marriage and abstained from sex during the last three months

The percentage of respondents who reported having had sex outside of marriage during the last three months is presented in Table 13. In the Intervention follow-up, respondents were from the Poor (17%) (Household assets), age (40+) and Primary (educational level). In the Control follow-up respondents were from the Rich (74%), age (40+) (74%) and Primary (educational level) (66%). The percentage of respondents who reported having abstained from sex during the last three months was Poor (67%) (Household assets), age (20-30) and Secondary (educational level) (59%) in the Intervention follow-up. In the Control follow-up, the Middle (household assets), age (31-39) and Secondary (educational level) of respondents reported having abstained from sex during the last three months.

Table 12: Percentage of respondents who reported having had sex outside of marriage and abstained from sex during the last three months

Characteristics	% Who reported having had sex outside of marriage during the last three months		% Who reported having abstained from sex during the last three months	
	Intervention follow-up	Control follow-up	Intervention follow-up	Control follow-up
Household assets				
Poor	16.7%	60.0%	66.7%	28.0%
Middle	5.5	60.6%	55.2%	39.4%
Rich	2.3	73.5%	30.8%	26.5%
Age				
20-30	0.0	61.5%	55.6%	28.2%
31-39	2.4%	58.8%	54.8%	39.2%
40+	4.8%	74.0%	45.2%	30.0%
Educational level				
Primary	4.1%	66.1%	42.9%	30.4%
Secondary	1.9%	64.3%	58.5%	34.5%

5.3.1.23 Sexual Behaviour

Sexual Behaviour findings are presented in Table 14. 78% of respondents in the Intervention group at baseline reported having had sexual relations in the past three months. During the Follow-up the percentage of respondents reduced to 35% and this shows that the intervention was effective in reducing the percentage of respondents with sexual relations in the past three months. Percentage of respondents in the Intervention Group reporting on the number of persons they had sex with in the past three months reduced from 34% (Baseline) to 27% (Follow-up) (1 relation), 26% (Baseline) to 8% (Follow-up) (2 relations), 8% (Baseline) to 0% (Follow-up) (3 relations) and 12% (baseline) to 1% (Follow-up) (4+ relations).

Table 13: Sexual Behaviour

Characteristics	Intervention-Group		Control – Group	
	Base-line	Follow-up	Base-line	Follow-up
Have you had sexual relations in the past three months?				
	21.4%	64.7%	33.4%	38.0%
No	78.0%	35.3%	66.6%	62.0%
Yes				
With how many different people have you had sex in the past three months?				
0	20.9%	64.1	15.9	21.5
1	33.5%	26.5	36.5	38.6
2	26.4%	7.8	28.7	20.5
3	7.7%	0.0	10.2	9.8
4+	11.5%	1.0	9.0	10.5
Do you currently have a boyfriend/ girlfriend or at least have had one during the last three months?				
No				
Yes	33.0%	93.1%	30.0%	35.2
	65.4%	6.9%	70.0%	64.8
How many times have you had sex with your boyfriend /girlfriend in the last three months?				
0				
1	32.4%	93.1	28.7	20.2
2	15.4%	2.9	15.9	21.8
3	9.9%	0.0	10.2	9.8
4+	7.1%	0.0	9.0	10.5
	35.2%	2.9	36.5	38.6
How often do you use condoms with your boyfriend/girl friend?				
Always	31.9%	93.1	27.1%	17.9%
Most of the time	22.5%	3.9	30.0%	11.4%
Half of the time	12.1%	0.0	3.6%	29.9
Sometimes	5.5%	0.0	10.0%	37.8
Never	28.0	2.9	6.7%	13.8
Have you had sex outside of marriage during the last three months?				
No	36.8%	97.1%	35.0%	38.0%
Yes	63.2	2.9%	65.0%	62.0%
With how many people have you had sex outside of marriage in the past three months?				
0				
1	36.8%	90.2	35.7	29.7
2	43.4%	6.9	36.0	41.3
3	12.6%	2.9	15.4	15.4
4+	1.6%	0.0	5.9	5.9
	5.5%	0.0	7.0	7.7
Number of concurrent sexual partners have had during the last three months				
0	35.2%	79.4	39.5	42.1
1	39.6%	17.6	26.5	27.5
2	11.5%	2.9	17.9	10.6
3	6.6%	0.0	10.5	9.7
4+	7.1%	0.0	5.6	10.5
In the past three months, have you adopted new				

behaviour (or Modified your behaviour) specifically to live positively				
No	81.3%	37.3%	60.5%	72.1%
Yes	18.7%	62.7%	39.5%	27.9%
What behaviour have you adopted in the last three months?				
Have abstained from sex				
No	92.9%	77.5%	87.0%	94.3%
Yes	7.1%	22.5%	13.0%	5.7%
No longer sex with casual partners				
No	89.0%	81.4%	88.3%	87.9%
Yes	11.0%	18.6%	11.7%	12.1%
Do you have safe sex yourself?				
No	51.6%	17.6%	59.3%	49.1%
Yes	48.4%	82.4%	40.7%	50.9%
Do you abstain from sex?				
No	74.2%	49.0%	67.1%	54.3%
Yes	25.8%	51.0%	32.9%	45.7%
Do you think abstinence (doing without sex) is possible?				
No	24.7%	8.8%	27.4%	34.3%
Yes	75.3%	91.2%	72.6%	55.7%

5.3.1.24 Percentage of respondents who reported having adopted new behaviour specifically to live positively

The percentage of respondents who reported having adopted new behaviour specifically to live positively is shown in Figure 19. In the Intervention Group, 81% of the respondents did not report having adopted new behaviour specifically to live positively while 19% reported having adopted new behaviour specifically to live positively at baseline. During the Follow-up 37% of the respondents did not report having adopted new behaviour specifically to live positively while 63% reported having adopted new behaviour specifically to live positively. In the Control-group, the percentage of respondents who did not report having adopted new behaviour specifically to live positively was 61% at baseline and this increased to 72% in the Follow-up. There was a significant change in the Intervention group after the intervention was implemented.

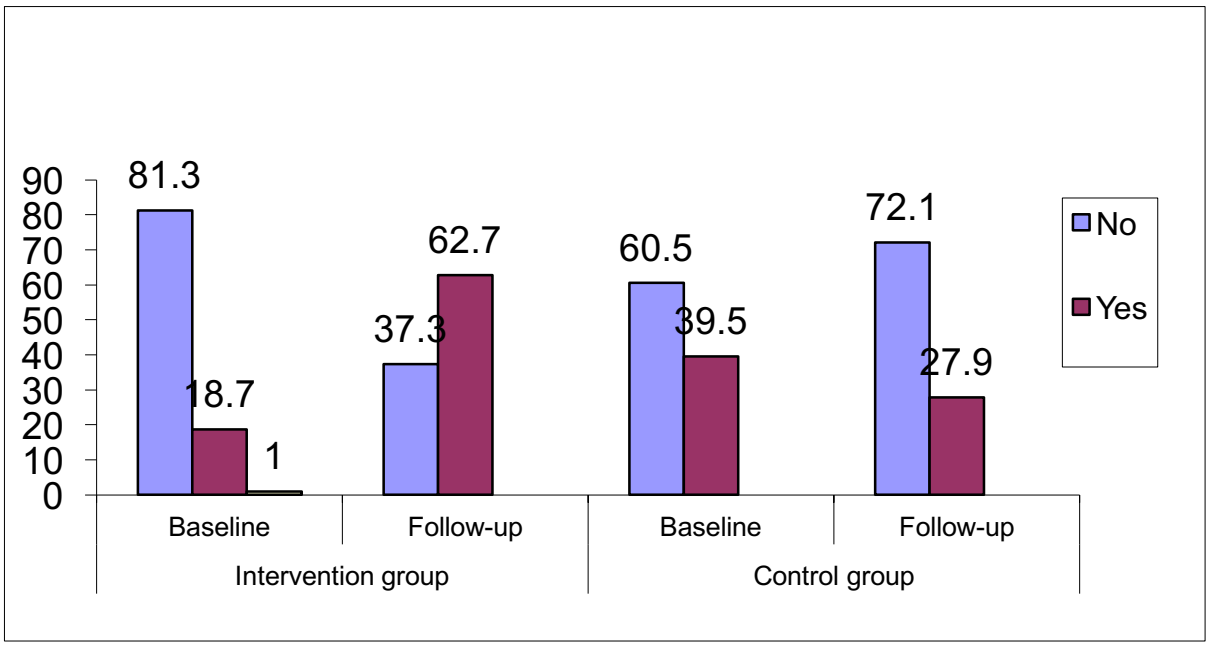

Figure 19: Percentage of respondents who reported having adopted new behaviour specifically to live positively

5.3.1.25 Percentage of respondents who reported having practiced safer sex with their partners

The percentage of respondents who reported having practiced safer sex with their partners is presented in Figure 20. At baseline 48% and 82% of the respondents reported having practiced safer sex with their partners at baseline and Follow-up, respectively. The percentage of respondents who did not practice safer sex with their partners reduced from 52% to 18% at baseline and follow-up, respectively.

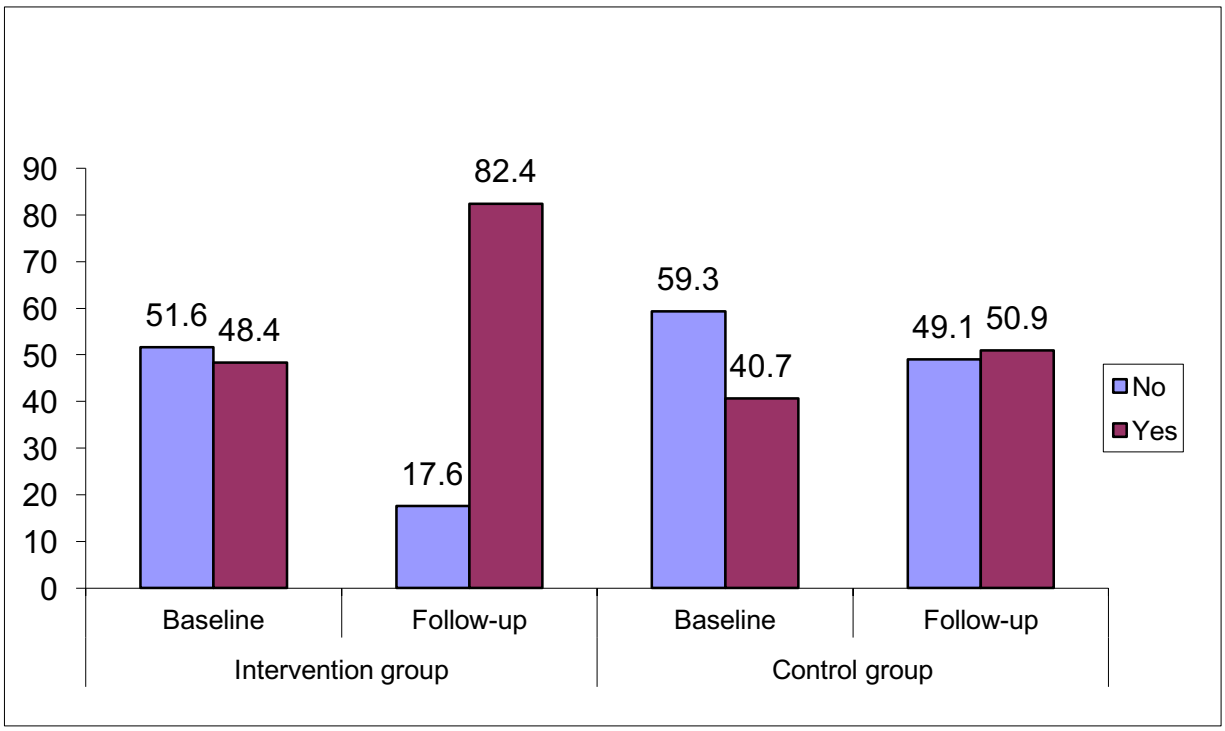

Figure 20: Percentage of respondents who reported having practiced safer sex with their partners

5.3.1.26 Percentage of respondents who reported having abstained from sex

The percentage of respondents who reported having abstained from sex are presented in Figure 21. 26% and 51% of respondents reported having abstained from sex at baseline and follow-up, respectively. 74% and 49% of the respondents reported not having abstained from sex at baseline and follow-up, respectively. There was an increase in the percentage of respondents who abstained from sex and a reduction in the percentage of respondents who did not abstain from sex. This shows that the intervention was effective.

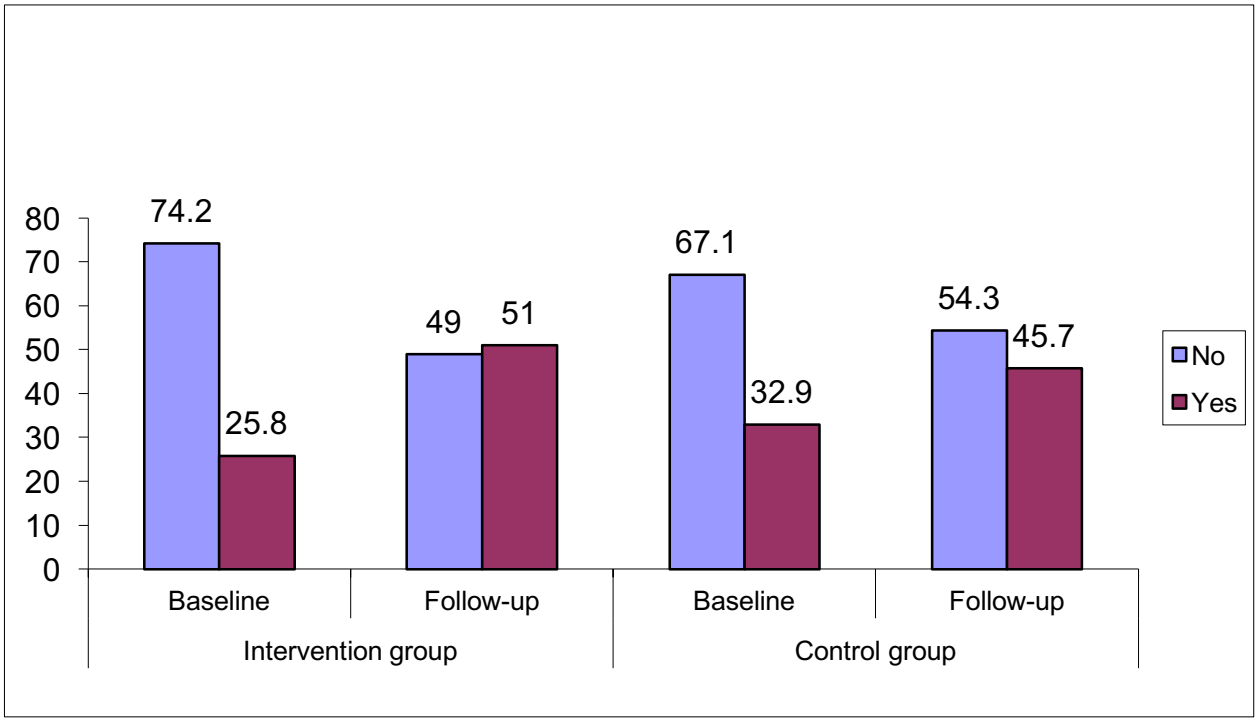

Figure 21: Percentage of respondents who reported having abstained from sex

5.3.1.27 HIV/AIDS Symptoms

Table 15 shows that the percentage of respondents who reported having experienced fatigue or loss of energy that keept them from the things that they needed or wanted, changed considerably after the intervention. At baseline 8% of respondents reported having never experienced fatigue or loss of energy compared to 42% of those during the follow-up. Similarly, at baseline 29% of respondents reported having never experienced loss of balance in walking or getting up from a chair or bed compared to 62% of those in the follow-up. Respondents from intervention group were more likely to report having never experienced skin problems such as a rash or sores or dryness compared to the control group. At baseline, 31% of respondents reported having never experienced skin problems compared to 72% of those in the follow-up survey. Concurrent with the same findings, 20% of respondents reported having

never experienced a cough of any type of severity during the baseline compared to 42% of those during the follow-up survey. Considerable changes were also noticed among those who had never experienced a headache of any type of severity. At baseline 15% of respondents reported having never experienced any headache of any type of severity compared to 27% during the follow-up.

Respondents from the intervention group were less likely to report having experienced significant weight lost during the last three months compared to 41% of those during the baseline. The percentage of respondents who believed that HIV/AIDS was a punishment from God for promiscuous people also changed considerably during the follow-up. At baseline 47% of respondents reported that HIV/AIDS was a punishment form God for promiscuous people compared to only 8% during the follow up. Similarly, at baseline 32% of respondents believed that AIDS is just one way of dying and it could not be avoided, compared to only 10% of those who said so during the follow-up. Furthermore, considerable changes were also noticed of those who reported that their health was excellent after the intervention. At baseline 19% of respondents reported that their health was excellent compared to 47% in the follow-up. Similarly, at baseline 26% of respondents reported feeling tired most of the time compared to only 5% of those reported so during the follow-up.

Table 14: HIV/AIDS Symptoms

Characteristics	**Intervention-Group**		**Control – Group**	
	Base-line	Follow-up	Base-line	Follow-up
Experienced fatigue or loss of energy that keeps you from doing the things you need or want to				
Never	7.7%	42.2%	19.7%	15.7%
Rarely	39.0%	34.3%	19.7%	40.0%
Sometimes	44.5%	20.6%	51.6%	27.1%
Often	8.8%	1.0%	9.0%	17.1%
Loss of balance in walking or getting up from a chair or bed				
Never	28.6%	61.8%	32.3%	47.9%
Rarely	41.8%	26.5%	39.7%	24.9%
Sometimes	24.7%	8.8%	19.8%	19.4%
Often	4.9%	1.0%	8.1%	7.9%
Skin problems, such as a rash, sores or dryness				
Never	31.3%	71.6%	68.6%	62.1%
Rarely	49.5%	17.6%	13.9%	18.6%
Sometimes	10.4%	7.8%	8.1%	7.1%
Often	4.4%	1.0%	9.4%	12.1%
Cough of any type of severity				
Never	20.3%	42.2%	42.2%	37.8%
Rarely	29.7%	38.2%	14.4%	10.7%
Sometimes	45.6%	13.7%	34.1%	43.6%
Often	3.8%	3.9%	9.4%	7.9%
Headache of any type of severity				
Never	15.4%	26.5%	18.4%	28.6%
Rarely	16.5%	34.3%	13.5%	45.7%
Sometimes	56.6%	31.4%	39.5%	14.2%
Often	10.4%	5.9%	28.7%	11.4%
Have you had significant weight lost during the last three months (unrelated to giving birth)				
No	51.1%	78.4%	63.5%	48.0%
Yes	41.2%	20.6%	36.5%	52.0%
Have you had a genital discharge during the past three months?				
No	92.9%	98.0%	79.3%	83.3%
Yes	7.1%	2.0%	20.7%	16.7%
Have you had a genital ulcer/sore during the past three months?				
No	84.6%	98.0%	71.4%	86.4%
Yes	15.4%	2.0%	28.6%	13.6%
Do you think HIV/AIDS is punishment from God for promiscuous people?				
No	52.7%	92.2%	57.1%	68.3%
Yes	47.3%	7.8%	42.9%	31.2%
Do you think AIDS is just one way of				

dying - it cannot be avoided?				
No	68.1%	90.2%	74.3%	60.1%
Yes	31.9%	9.8%	25.0%	39.0%
In general, would you say your health is?				
Excellent	1.1%	10.8%	8.9%	4.3%
Very good	18.7%	47.1%	16.6%	17.9%
Good	50.5%	35.3%	22.0%	57.1%
Fair	27.5%	1.0%	34.1%	14.2%
Poor	2.2%	2.0%	18.4%	6.4%
Do you feel tired?				
Most of the time	25.8%	4.9%	46.6%	38.5%
Some of the time	32.4%	36.3%	10.7%	12.1%
A little of the time	38.5%	28.4%	15.2%	14.3%
None of the time	3.3%	28.4%	28.3%	35.0

5.3.1.28 Alcohol & Drug Abuse

The percentage of participants who reported they had ever taken alcohol in the Intervention group was 76% (Baseline) and 28% (Follow-up). In the Control-group the percentage of participants who reported they had ever taken alcohol were 69% (Baseline) and 57% (Follow-up). Participants taking alcohol during the last three months dropped from 7% (Baseline) to 0% (Follow-up) (Every day), 29% (Baseline) to 1% (Follow-up), (At least once a week) and 28% (Baseline) to 24% (Follow-up) (Less than once a week) in the Intervention Group. Percentage of participants who report having taken different types of drugs during the last three months dropped from 14% (Baseline) to 0% (Follow-up) in the Intervention Group.

Percentage of participants in the Intervention Group who reported having sniffed (snorted), swallowed, or smoked any drug or something to make you feel high drop from 2% (Baseline) to 0% (Follow-up). The percentage of participants who have ever smoked, drunk in a bar, danced in a night club or smoked cigarettes in the Intervention Group dropped from 21%, 26%, 9% and 8% (Baseline) to 5%, 3%, 0% and 0% (Follow-up), respectively. Results indicate that the intervention was

effective in the Intervention group while in the Control-group, there were a smaller change between the Baseline and Follow-up survey.

Table 15: Alcohol & Drug Abuse

Characteristics	**Intervention-Group**		**Control - Group**	
	Base-line	Follow-up	Base-line	Follow-up
% Who reported had ever taken alcohol				
No	24.2%	71.6%	30.7%	42.9%
Yes	75.8%	28.4%	69.3%	57.1
How often had taken alcohol during the last three months				
Every day	6.6%	0.0	10.7%	9.9
At least once a week	28.6%	1.0%	36.4%	35.7
Less than once a week	27.5%	23.5%	30.0%	31.9
% Of who report having taken different types of drugs during the last three months				
No	86.3%	100.0	78.6%	81.6%
Yes	13.7%	0.0	21.4%	18.4%
% Of who reported having sniffed (snorted), swallowed, or smoked any drug or something to make you feel high				
No	97.8%	100.0	90.0%	89.1%
Yes	2.2%	0.0	10.0%	10.9
Have you ever smoked?				
Yes	78.6%	95.1%	80.0%	92.8%
No	21.4%	4.9%	20.0%	7.2%
Drinking in a bar				
No	74.2%	96.1%	76.4%	80.6%
Yes	25.8%	2.9%	23.6%	19.4%
Dancing in a night club				
No	90.7%	100.0	85.0%	88.2%
Yes	9.3%	0.0	15.0%	10.8%
Smoked Cigarettes				
No	92.3%	100.0	92.9%	87.8%
Yes	7.7%	0.0	7.1%	12.2%

5.3.1.29 Coping Strategies

The percentage of respondents' characteristics and coping strategies in the Intervention and Control groups during the Baseline and Follow-up are presented in Table 17. The percentage of respondents in the Intervention group who reported worry about what they should do to prevent AIDS are as follows: Strongly agree (35% Baseline, 13% Follow-up), Somewhat agree (25% Baseline, 0% Follow-up), Somewhat disagree (6% Baseline, 16% Follow-up) and Strongly Disagree (35% Baseline, 72% Follow-up). The percentage of respondents who reported on coping strategies in the Intervention Group who have been using alcohol or other drugs/medication "to make myself feel better" are as follows: Strongly agree (20% Baseline, 7% Follow-up), Somewhat agree (6% Baseline, 0% Follow-up), Somewhat disagree (14% Baseline, 7% Follow-up) and Strongly Disagree (60% Baseline, 86% Follow-up). From the results, the percentage of respondents who Strongly agree, somewhat agree or Somewhat disagree reduced in the Follow-up, whilst the percentage of respondents who Strongly disagree increased during the Follow-up. This shows that the intervention was effective in changing the key characteristics and coping strategies among the respondents. Within the Control-group they were insignificant changes in the characteristics and coping strategies among the respondents.

Table 16: Coping Strategies

Characteristics	**Intervention-Group**		**Control – Group**	
	Base-line	Follow-up	Base-line	Follow-up
I worry about what I should do to prevent AIDS.				
Strongly agree	34.6%	12.7%	36.8%	32.1%
Somewhat agree	24.7%	0.0	18.4%	12.9%
Somewhat disagree	6.0%	15.7%	13.0%	7.9%
Strongly Disagree	34.6%	71.6%	32.7%	47.1%
My risk for AIDS seems to be increasing				
Strongly agree	22.0%	3.9%	11.7%	33.6%
Somewhat agree	17.6%	0.0	16.1%	12.9%
Somewhat disagree	25.8%	22.5%	26.9%	25.0%
Strongly Disagree	34.6%	73.5%	45.3%	28.6%
The fear of God makes me feel nervous about engaging in sex outside of marriage				
Strongly agree	58.8%	86.3%	61.7%	44.3%
Somewhat agree	22.0%	6.9%	27.0%	27.9%
Somewhat disagree	9.9%	1.0%	5.8%	14.3%
Strongly Disagree	9.3%	5.9%	5.4%	13.6%
Religious teaching hasn't really affected my behaviour				
Strongly agree	24.7%	6.9%	13.9%	15.7%
Somewhat agree	19.2%	2.9%	18.4%	22.1%
Somewhat disagree	17.6%	3.9%	16.6%	21.4%
Strongly Disagree	38.5%	86.3%	51.1%	40.7%
I am not concerned about sex outside of marriage				
Strongly agree	18.7%	20.6%	20.2%	32.1%
Somewhat agree	14.8%	3.9%	20.2%	23.6%
Somewhat disagree	34.6%	25.5%	14.3%	25.7%
Strongly Disagree	31.9%	50.0%	18.8%	18.6%
I will avoid having sex outside of marriage altogether				
Strongly agree	48.4%	91.2%	34.3%	50.4%
Somewhat agree	23.1%	2.9%	31.4%	21.5%
Somewhat disagree	12.6%	1.0%	16.4%	22.7%
Strongly Disagree	15.9%	4.9%	17.9%	5.4%
Going for prayer meetings is beneficial				
Strongly agree	68.1%	88.2%	50.7%	52.1%
Somewhat agree	18.7%	11.8%	14.3%	26.6%
Somewhat disagree	7.7%	0.0	21.4%	1.3%
Strongly Disagree	5.5%	0.0	13.6%	19.0%
Going for prayer meetings improves one's health				
Strongly agree	54.4%	90.2%	48.6%	55.3%
Somewhat agree	28.6%	7.8%	15.7%	22.4%
Somewhat disagree	7.7%	1.0%	20.0%	10.9%

Strongly Disagree	9.3%	1.0%	15.7%	11.3%
Coping strategies				
I have been using alcohol or other drugs/medication to make myself feel better				
Strongly agree	19.8%	6.9%	30.0%	23.1%
Somewhat agree	6.0%	0.0	10.7%	11.3%
Somewhat disagree	13.7%	6.9%	12.1%	19.0%
Strongly Disagree	60.4%	86.3%	47.1%	46.5%
I have been giving up trying to deal with the situation.				
Strongly agree	13.2%	6.9%	13.9%	30.7%
Somewhat agree	9.9%	5.9%	17.5%	20.7%
Somewhat disagree	35.2%	24.5%	22.4%	30.0%
Strongly Disagree	41.8%	62.7%	46.2%	18.6%
I have been criticizing myself				
Strongly agree	20.9%	5.9%	21.5%	33.6%
Somewhat agree	25.3%	7.8%	21.1%	21.4%
Somewhat disagree	22.0%	22.5%	22.0%	16.4%
Strongly Disagree	31.9%	63.7%	35.4%	28.6%
I have been getting emotional support from other people				
Strongly agree	28.0%	54.9%	38.9%	25.0%
Somewhat agree	39.0%	13.7%	31.8%	43.6%
Somewhat disagree	18.7%	3.9%	14.0%	19.3%
Strongly Disagree	14.3%	27.5%	15.2%	12.1%
I have been getting comfort and understanding from someone else				
Strongly agree	40.7%	61.8%	42.6%	37.9%
Somewhat agree	35.2%	10.8%	36.8%	25.0%
Somewhat disagree	11.5%	1.0%	5.4%	10.0%
Strongly Disagree	12.6%	26.5%	15.2%	27.1%
I have been using alcohol or other drugs/medications to help me get to know what to do.				
Strongly agree	11.0%	0.0	21.8%	28.6%
Somewhat agree	12.6%	0.0	13.6%	17.1%
Somewhat disagree	7.1%	3.9%	14.3%	14.3%
Strongly Disagree	69.2%	96.1%	50.3%	40.0%
I have been blaming myself for things that happened				
Strongly agree	34.1%	9.8%	30.5%	41.4%
Somewhat agree	13.7%	6.9%	13.9%	13.6%
Somewhat disagree	24.7%	23.5%	16.1%	30.7%
Strongly Disagree	27.5%	59.8%	39.5%	14.3%
I have been arguing with other people around me				
Strongly agree	15.4%	10.8%	18.8%	22.9%
Somewhat agree	19.2%	3.9%	22.9%	27.9%
Somewhat disagree	25.3%	13.7%	18.8%	22.9%
Strongly Disagree	40.1%	71.6%	39.5%	26.4%

5.3.1.30 Percentage of respondents who reported abstaining from sex was possible

The percentage of respondents who reported abstaining from sex was possible is shown in Figure 22. The percentage of respondents who reported abstaining from sex was possible are 75% (Baseline) and 91% (Follow-up) in the Intervention Group. This indicates that the intervention was effective which led to a higher percentage of respondents who reported that it was possible to abstain from sex. In the Control-group the percentage of respondents who reported abstaining from sex was possible is 73% (Baseline) and 56% (Follow-up). Results from the Control group indicate that the percentage of respondents who reported abstaining from sex was possible reduced. It is reasonable to deduce absence of the intervention in the control group was a key factor impacting the said outcome.

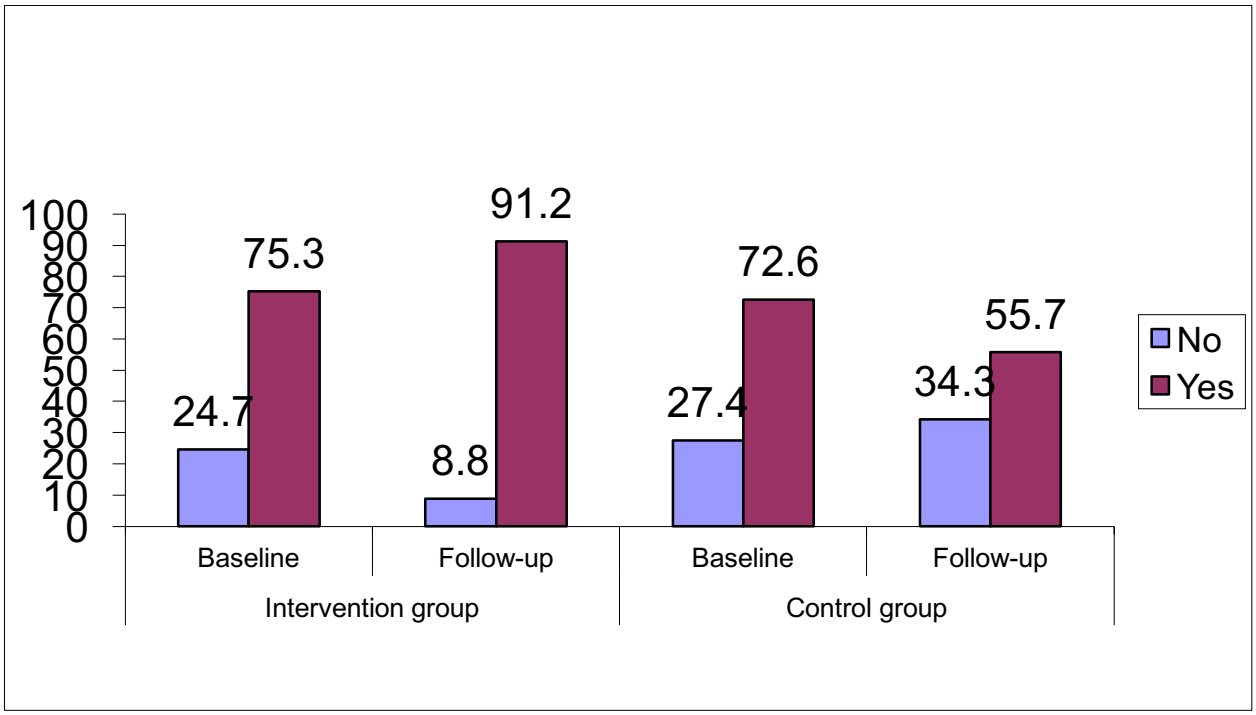

Figure 22: Percentage of respondents who reported abstaining from sex was possible

5.3.1.31 Determinants of sexual behaviour

The results on determinants of sexual behaviour are as presented in Table 18. The percentage of respondents who reported having had sex with two or more partners in the past three months was significantly lower ($P < 0.05$) among single (marital status) working males with Poor household status who did not participate in the faith-based seminar. The percentage of respondents who reported having had sex outside of marriage during the last three months was significantly higher ($P < 0.01$) among participants who did not participate in the faith based seminar. The percentage of respondents who reported having had sex with concurrent partners during the last three months was significant at $P < 0.05$ among working males who did not participate in the faith-based seminar.

Table 17: Determinants of sexual behaviour

	% Who reported having had sex with two or more partners in the past three months	**% Who reported having had sex outside of marriage during the last three months**	**% Who report having had sex with concurrent partners during the last three months**
Sex			
Male	39.2**	46.4	55.7**
Female	28.9	39.0	45.5
Age			
20-30	32.7	50.9	54.5
31-39	32.8	35.3	42.9
40+	31.8	43.6	52.7
Educational level			
Primary	32.2	38.8	50.4
Secondary	32.5	43.6	47.9
Marital status			
Single	24.3**	39.6	47.9
Currently Married	40.7	43.6	50.0
Work status			
Working	27.9**	39.6	42.9**
Not working	37.7	43.8	56.2

Household assets			
Poor	45.5**	49.4	58.4
Middle	26.3	36.8	43.6
Rich	29.7	41.9	48.6
Participation of faith based seminar			
Not attended	42.3***	61.5***	62.6***
Attended	14.7	5.9	24.5
N	32.4	41.5	48.9

Significance level: ** P<0.05 ***P<0.01

5.3.1.32 Determinants of safe sexual practices

Determinants of safe sexual practices are presented in Table 19, below. The percentage of respondents who reported having adopted new behaviour or modified old behaviour specifically to live positively was significant at $P < 0.05$ among males who did not participate in the faith-based seminar. The percentage of respondents who reported practicing safer sex was significant at $P < 0.05$ in the age group 20-30 among those who did not participate in the faith-based seminar. The percentage of respondents who reported abstaining from sex was significant at $P < 0.05$ among respondents with Primary Educational level, single (marital status) and Poor (Household assets) of those who did not participate in the faith-based seminar. The percentage of respondents who thought that abstinence is possible was significant at $P < 0.05$ among respondents in the age group (20-30) with primary educational level who did not participate in the faith-based seminar.

Table 18: Determinants of safe sexual practices

	% Who reported having adopted new behaviour or modified old behaviour specifically to live positively	% Who reported practicing safer sex	% Who reported abstaining from sex	% Who thought that abstinence is possible
Sex				
Male	27.8**	64.9	37.1	81.4
Female	38.0	58.3	33.7	80.7
Age				
20-30	34.5	70.9*	32.7	83.6**
31-39	35.3	52.9	37.8	85.7
40+	33.6	63.6	32.7	74.5
Educational level				
Primary	36.4	62.8	29.8**	76.9**
Secondary	33.1	58.9	38.7	84.0
Marital status				
Single	34.7	58.3	39.6***	84.0
Currently married	34.3	62.9	20.0	77.9
Work status				
Working	31.2	57.8	37.7	82.5
Not working	38.5	63.8	31.5	79.2
Household assets				
Poor	26.0	55.8	24.7*	77.9
Middle	36.1	60.9	39.8	80.5
Rich	40.5	64.9	36.5	85.1
Participation of faith based seminar				
Not attended	20.3***	54.4***	29.7**	75.8***
Attended	59.8	71.6	44.1	90.2
N	34.5	60.6	34.9	81.0

Significance level: ** P<0.05 ***P<0.01

5.3.1.33 Determinants of alcohol and drug abuse

Determinants of alcohol, drug and cigarette abuse are presented in Table 20. The percentage of respondents who reported taking alcohol was significant at $P < 0.05$ among males who did not participate in the faith-based seminar. The percentage of respondents who reported taking drugs (14%) and smoked cigarettes (23%) were significantly higher at $P < 0.01$ among respondents who did not participate in faith-based seminar.

Table 19: Determinants of alcohol and drug abuse

	% Who reported taking alcohol	% Who reported taking drugs	% Who had ever smoked
Sex			
Male	38.3**	11.3	20.6
Female	61.7	7.5	12.8
Age			
20-30	18.6	10.9	18.2
31-39	43.1	10.1	11.8
40+	38.3	6.4	18.2
Educational level			
Primary	39.5	8.3	18.2
Secondary	60.5	9.2	13.5
Marital status			
Single	56.9	8.3	13.2
Currently	60.7	9.3	17.9
Married			
Work status			
Working	59.7	7.1	18.2
Not working	57.7	10.8	12.3
Household assets			
Poor	55.8	10.4	18.2
Middle	54.9	7.5	14.3
Rich	68.9	9.5	14.9
Participation in faith-based seminar			
Not attended	73.1***	13.7***	23.1***
Attended	33.3	0.0	2.0

Significance level: ** P<0.05 ***P<0.01

5.3.1.34 Logistic Regression Analysis

Results of the logistic regression analysis as presented in Table 21. show that respondents who participated in the congregation f-based Seminars were *4.1 times* more likely to report having adopted new behaviour or modified old behaviour, specifically to live positively than those who did not attend the faith based seminar. Similarly, those who participated in the Congregation based Life Transformation Seminars were *2.3 times* more likely than those who did not participate in the seminars to report having adopted safer sexual practices. The results of the analysis

further reveal that those who participated in the Congregation based seminars were more likely to report abstinence from sex than those who did not attend the seminars.

Table 20: Logistic Regression Analysis

	Odds that respondents would adopt new behaviour or modify old behaviour specifically to live positively	Odds that respondents would practice safe sex with partners	Odds that respondents would abstain from sex
Sex			
Male			
Female	.7574	.6894	.6660
Age			
20-30			
31-39	.7574	.3621	1.2356
40+	.7207	.5555	.9335
Educational level			
Primary			
Secondary	1.1324	.7754	1.4060
Marital status			
Single			
Currently married	1.0585	1.1432	.6199
Work status			
Working			
Not working	1.4446	1.1727	.6600
Household assets			
Poor			
Middle	1.1477	1.0504	2.0063**
Rich	1.9064	1.5005	1.8396
Participation in faith-based seminar			
Not attended			
Attended	4.1110***	2.3813**	1.8552**

Significance level: ** P<0.05 ***P<0.01

5.4 Qualitative Findings

This section presents the results from in-depth interviews with the participants of the LTS. The background characteristics of the respondents are presented in Section 5.3.1.1 above.

Further to the themes generated through coding and sorting of the data in *Atlas.ti 5.0* software, the grounded theory (Strauss and Corbin 1990 & 1998) was utilised for additional practical exploration of the impressions and impact experienced by the informants. Matthews, 2005 recommended the need for a conceptual framework that is "ground in the data." Creswell, 2007 explained that a grounded theory approach enables the researcher to "develop a theory from examining many individuals who share in the same process, action and interactions." The study elected a modified 'systematic' (Strauss and Corbin 1998) rather than 'constructivist' (Charmaz, 2005, 2006) approach as guided by Creswell (2007) in a discussion. There appear to be multiple notable correlations between the qualitative findings (below) and the quantitative results presented already.

The key thematic aspects generated through sorting are highlighted here and explained briefly. Following that, a two tier thematic consolidation is done (in the discussion section) to consider two emerging themes inferred from the qualitative data in relation to the research objectives.

First, a look at 15 emergent aspects of the impressions of respondents gleaned on the basis of the independent and dependent variables selected for the study.

5.4.1 Programme's General Impact on Participants

In response to the question- *In what ways has attending the programme impacted the overall wellbeing of your life?* Respondents reported the intervention to have been relevant and informative, providing various categories of information on HIV and AIDS such as positive living. They noted the importance of taking care of their health including eating healthy foods, and resting. Additionally, they highlighted the need for healthy relationships with their spouses and children as well as with the wider community, as per recorded impressions below:

> I have come to accept my situation; that I am HIV positive and that I can live positively and healthy. I want to live well and eat well and spend a lot of time resting. (INF5 007)

> Now I have learnt that I need to forget about my past …and accept my [HIV positive] status. (INF5 006)

> This teaching has really helped…after attending this programme, I have been encouraged a lot…I now know how to take care of myself, eat well. (INF5 001)

5.4.2 Programme's Impact on Christian Faith

As is the case in many faith-based initiatives, participants from various backgrounds invariably end up making direct personal inquiries regarding faith itself. This often results in eventual acceptance of Jesus Christ as their Saviour and in Evangelical jargon, they are said to have been born again.[1] While the LTS was based on biblical content, its aim was not to convert individuals. However, since one of the key independent variables included personal *faith*, respondents were asked if they had

[1] Evangelical Christians generally and Pentecostals in particular, espouse practically the imperative of what is termed in Christian Mission as the Great Commission mandate given by Jesus in the biblical book of Matthew 28:1-20 as a mission for believers in Christ Jesus to spread the gospel message to as many persons as they interact with. This may result in the person talked to being converted to Christ (being *born again* as per biblical book of John 3:3). Al Tizon aptly highlighted the Greek linguistic root of the term 'evangelical' as one that "simply refers to someone who believes the '*euangelion,*'or the *gospel of good news* and who has a 'burning passion for the communication of the Gospel.'

ever been born again. The majority (54%) indicated having the experience of salvation. Of those who had not been born again, Informants reported that the Intervention contributed to their being born again and subsequently, their growth in the faith.

Qualitative data showed that while some reported having been born again prior to the LTS, experience with the Life transformation seminar gave them a more genuine feeling of been born again than previously. For instance, one participant remarked:

> "I have learnt so many things from the word of God. To be honest with you, before I started attending these sessions, I was not born again. I have now learnt what it means to be born of the Spirit and to live for God." (INF2 003)

5.4.3 Programme's Impact on Prayer Life

The Study featured prayer as one of the independent variables, partly on account of the fact that it has an important role in the life of a Christian. The intervention was seen as having contributed immensely to the improving of the participants' prayer life in various ways. Quantitative findings showed that the participants' reported prayer life had improved both in terms of frequency of prayer itself, frequency of attendance of prayer meetings as well as frequency in attending church services.

The follow-up study revealed that 73% of the participants prayed more regularly at different occasions during the last four weeks compared to 52% during the baseline. While 16% reported not having prayed at all during the last four weeks, only 3% had not prayed during the follow-up. Qualitative findings showed that the intervention had improved their knowledge regarding prayer. They also reported having gained knowledge about the importance of prayer and its power with regards to its ability to provide or to bring about change in a person's life. For some

participants, they were now able to pray without being afraid that this would cause them to be mocked or ridiculed by friends and other community members.

Some participants reported that beyond learning how to pray in a group, they had acquired the motivation, confidence and ability to pray on their own; the ability to have concentration during prayer without having the mind wandering; as well as the ability to pray for a longer duration. For example, two female participants and three male participants, respectively reported as follows:

"I have learnt a lot such as praying all the time; whether I have money or not. I know that ultimately, God will provide."(INF10 005)

I have learnt how to pray and believe God for results, knowing that God loves me and hears my prayers. I have learnt to pray without fear that others will laugh at me. (INF7 004)

I am able to remember to pray every time before meals. I never managed to pray after waking up, before sleeping and before eating. I never used to allow God in everything that I did. (INF8 004)

I have learnt how to pray on my own; I can stand and pray on my own. My prayer life has greatly improved. I can now pray for a long period of time without getting tired as opposed to the way it was before attending this programme. (INF2 006)

I am now able to pray any time without problems. Before, there was lack of concentration when praying. I never used to finish praying but would sleep as I prayed. I even feared praying for the children in my house. Now I have the zeal and I am able to pray without any disturbance and I always finish my praying. I can now pray for my children. (INF9 002)

5.4.4 Programme's Impact on Bible Reading

The programme had helped to increase participants' frequency of reading the Bible. During the follow-up, almost half (49%) of the respondents reported reading the Bible everyday compared to 24% during the baseline. Similarly, fewer respondents (7.8%) reported not reading the Bible at all during the follow-up compared to 12% during the baseline. For example, who previously had difficulty understanding the Bible reported:

I can now read the word of God on my own and understand whereas before, I never used to understand. (INF1 001)

5.4.5 Programme's Impact on Meetings and Fellowship

An individual's standing and strength as a Christian is dependent, among other factors, on the extent to which he or she is able to meet with fellow Christians. The programme aimed to improve the participants' Christian life by encouraging fellowship among them. This improvement was reflected by change in the frequency with which they attended church services and prayer meetings.

The frequency of attendance of prayer meetings increased from 14% during the baseline to 18% percent during follow-up. Similarly, frequency of attendance to church services increased, as 4.9% reported never attending church during the baseline compared to 0% during the follow-up. Admittedly, in relation to AIDS prevention, the real test of this outward show of commitment to meetings and fellowship is the eventual behaviour change in relation to adopting a less risky life style. Further personal testimonies of respondents below confirm this hypothesis.

5.4.6 Programme's Impact on Information and Knowledge

Participants thought the programme had provided them with information on various issues including HIV, AIDS, and other sexual reproductive issues. For example, stigma seemed to have been reduced from the baseline to the follow-up study. This is reflected by the proportion of those who perceived that HIV/AIDS was punishment from God for promiscuous people, 92% during the baseline and 53% during the follow-up. For instance, a participant who felt they had overcome successfully the problem of self-stigma and that of blaming God for the illness remarked:

I used to think and ask myself why me Lord, why am I going through this. Now, I have changed my thinking and I have come to know that it is not God who is the cause of sickness. (INF5 002)

5.4.7 Programme's Impact On Sexual Abstinence

Very prominently, participants' responses showed that the programme had had reasonably significant influence on the level of abstinence from sex. As a result, sexual activity outside marriage settings, at least as per disclosure by respondents to fellow programme participants, seemed to have been reduced (particularly in reference pre-marital and extra-marital sex). This is consistent with quantitative findings, which revealed that fewer unmarried respondents reported having had sex in the last three months in the follow-up stage (35%) than at baseline (78%). This is a trend needing further investigation especially in view of the public notion that people generally, inclusive of marriage settings, want more not less sex and often this appears to be perceived as somewhat linked to a person's happiness. However ever, research results published by the Society for Personality and Social Psychology in the USA pointed in a different direction by stating:

"although more frequent sex is associated with greater happiness, this link was no longer significant at a frequency of more than once a week." Some previous studies, and a plethora of articles and self-help books, have claimed that more sex equals more happiness. But this study, based on surveys of more than 30,000 Americans collected over four decades, is the first to find that association is not there after couples' report having sex more than once a week on average. The study was not designed to identify the causal process, so does not tell us whether having sex up to once a week makes couples happier, or being in a happy relationship causes people to have more frequent sex (up to once a week).[2]

In the parameters of this study, it may be reasonable to infer that the Intervention may have influenced or affected their adherence to ideals of abstinence, marital fidelity or at least other behavioural change values espoused during the seminars.

[2] https://www.sciencedaily.com/releases/2015/11/151118101718.htm- Accessed 21 November, 2015

Some respondents reported having been very used to sexual relationships and stated that they had initially strongly believed it was impossible for them to stop the practice. However, at follow-up stage, they reported that the programme had enabled them to cut their sexual ties with their pre-marital or extra-marital sexual partners. For example, four participants each of whom felt they had successfully managed to employ abstinence from sex as an act of preventing new HIV infections in their respective circumstances reported:

I used to think abstinence was not possible but now I know it is very possible. (INF1 001)

I am able to abstain from sex (pre-marital). Before the programme, I used to fail to abstain from sex. (INF6 009)

I think for now I will continue to abstain (premarital) until the right time for me to have sex. (INF1 003)

Despite being a widow, I never abstained, but I was in wrong relationship. After the programme I have resorted to abstaining. (INF2 004)

5.4.8 Programme's Impact On Marital Fidelity

The intervention also contributed to reducing or even stopping multiple and concurrent sexual relationships. The number of programme participants who reported having had sex with more than one sexual partner in the last three months reduced from 46% during the baseline to 9% during the follow-up.

Similarly, the number of participants who reported having had sex outside of marriage during the last three months decreased from 63% during the baseline to 3% during the follow-up phase. For example, one female and two male participants respectively, who had successfully adopted fidelity as their new behavioural pattern each reported as follows:

I used to have so many boyfriends and sexual partners. But now…all is now well. (INF1 002)

I used to have extra marital relationships with other men, but not anymore. My life has really changed and God is at work. I used to think that you could have extra marital relationships and think all is well. But after this programme, I know that the truth is it is not pleasing to God to be unfaithful in marriage. God wants a marriage that is full of faithfulness and fidelity. (INF1 001)

Before I used to have other partners beside my wife, but now because of the transformation, which has taken place, I have decided to only stick to my wife and no other partners…Before the programme, I was not faithful to my wife. But now I am 100% faithful to my wife. I do not look to any other woman but am committed to my wife. (INF2 001)

5.4.9 Programme's Impact On Beer Drinking

One other practice that the programme around which the data showed there had been significant change is the drinking of alcohol. Respondents reported having been assisted towards withdrawal from drinking alcohol. During the follow-up, only 1% of respondents reported having taken alcohol at least once a week compared to 29% in the baseline. The data show that those who were involved in the programme had either stopped or reduced on taking alcohol.

Keeping in mind the social dynamic that may be at play in a person's life, it is usually their closest friends that they may then be wishing to talk to about their new found life. Respondents reported that the fact they no longer drank alcohol had reduced exposure to risky life styles. They said it implied that they no longer found themselves in places or situations that put them at risk of being tempted into pre-marital or extra marital sexual relationships as a result of the influence of alcohol. For example, four middle aged male participants who reported they each had overcome the problem of alcoholism in their individual lives said:

This programme has helped me over certain habits that held me in bondage over long periods of life. I never knew I would be free from alcohol. I used to drink beer a lot… Now I have stopped drinking. (INF5 010)

The programme has helped me realize the importance of forsaking a life of drinking going out to nightclubs, alcohol and sexual immorality. (INF4 008)

The programme has brought change in my life in that I was an alcoholic for years, but now I have stopped drinking. (INF2 001)

I was struggling with drinking alcohol; going to nightclubs. But now I have given up drinking alcohol and I no longer go to nightclubs. (INF4 005)

5.4.10 Programme's Impact on Smoking and Drugs

About 14% of respondents during the baseline, reported having taken different types of drugs in the last three months, compared to 0% during the follow-up. For example, one male participant in his mid thirties said happily:

I have stopped smoking. (INF3 00)

5.4.11 Programme's Impact HIV+ Living

Positive Living from an HIV perspective: Respondents reported enhanced desire for positive living. The programme taught participants that it was possible for them to prevent AIDS through positive living. For example, 68% of the participants during the baseline compared to 90% during the follow-up felt that AIDS was not just one way of dying and therefore, there was something that they could do about it. The programme was also reported to have helped the participants to learn to deal with their problems including worry and stress. For example, one male and three female participants respectively, stated:

This programme has helped me to have good thoughts and getting rid of bad thoughts. (INF2 003)

I have learnt not to keep on the wrong path or to dwell on wrong thought patterns, but not depend on Jesus who is able to heal me. To have a free mind and not to underrate myself because God is able to lift me up as we are all His children. (INF3 006)

This programme has helped me stop worrying about HIV and has instead taught me how to deal with fear and emotional stress. (INF5 007)

This programme has helped me overcome fear of death in my life and now I no longer fear death. (INF5 010)

I used to worry a lot and this used to rob me of joy, peace and happiness in my life. But now I am no longer going to continue focusing on worries. (INF4 004)

When asked if they had either adopted new behaviour or modified their old behaviour in the past three months, specifically to live positively, a larger proportion of respondents reported that they had adopted or modified their behaviour during the follow-up (63%) than during the baseline (19%).

Participants reported adopting a positive outlook about life as well as a new sense of self-belief and self-perception. For example, some participants reported having started to have positive, rather than negative thoughts about their personal lives, including their self-perception and the need to avoid self-condemnation. They reported a new approach of looking to the future with hope rather than dwell on their past. For example, the following five participants each stated:

Most of the time, I had negative thoughts about my life. This programme has challenged me to start building positive thoughts…I have started speaking positively over my life. (INF4 004)

I have learnt that I need to forget about my past…to think positively about myself and not to feel condemned or look down on myself. (INF5 006)

I have stopped condemning myself. (INF5 007)

This programme has taught me not to condemn myself. (INF5 0011)

I believe that there is hope for me even though I am HIV positive – it is not the end of the world. (INF5 004)

In particular, participants reported having learnt to accept their sero-positive status, something that had previously been difficult to do. For the first time, some participants were able to talk about their sero-status openly with other people. For example, five participants who reported that the Life transformation seminar had helped them 'break the silence' regarding their sero-status, each said:

It was not an easy thing to accept my HIV positive status. (INF4 004)

It was not easy to accept my status and every time I thought about it, I would cry in my room and my friends would come to get me and we would go out to drink; sometimes the whole night. (INF5 010)

Accepting my HIV positive status was a very difficult thing to do and I ended up doing many other bad things. (INF5 006)

Accepting my HIV positive status was a very difficult thing to do and I ended up doing many other bad things. (INF5 006)

This programme has taught me to accept my situation. (INF5 0011)

Generally, the programme seemed to have influenced various changes in the participants' attitude about life and their ability to lead a normal life despite being sero-positive. Data showed that not only did this cultivate in them, a reason for living but it also it revived their aspirations and motivation to "get back to living normally." Some confessed they had, prior to LTS, felt 'abandoned' either as a result of poor health or simply because of the knowledge that they were HIV positive. For example, each of those who appeared like they had just received a new lease of life reported:

The life transforming seminar has helped me rediscover my identity and focus my life again. I was living an empty life; a life void of peace and full of anxiety. I thought life had no meaning at all and I therefore wished to die. (INF5 008)

I did not want to work. I had given up even taking medication I was just doing it to keep myself alive, at least now I have a reason to live. I never knew God loved me this much and He doesn't want me to be sick but wants me well. (INF5 003)

It was as if everything that was being taught was directed at me alone. My business has been down for a while and I was about to quit because of my health. I was prepared to die and did not see any reason to continue running my business. This programme has helped me to understand that I do not need to give up on anything in this life and that God is a God of a second chance. (INF5 013)

5.4.12 Programme's Impact On Physical and Mental Health

The programme was also reported a positive effect on the participants' mental as well as physical well-being. And a sense of happiness and well being were among

the chosen dependent variables for the study. Reportedly, their new state was mainly as a result of the fact that the programme had taught them to believe that God could heal them or their family members. They reported that the programme had taught them how to receive healing from God. Even when they had not yet been healed, or had been partially healed, many participants reported having been helped to develop a strong belief that healing would eventually come. For example, four participants each stated:

> Sometimes we have doubts that God will heal us. I have however learnt that I can get whatever I want in life as long as I truly believe that it can happen. My faith is what will get the results done. Therefore, I believe that through this programme, my faith; if it is strong enough will produce the healing I desire so much. (INF 5 005)

> I have just known that God loves me and I have confidence that if He loves me that much, then He will definitely heal me. (INF5 005)

> Before the programme, I used to have doubt in my faith, especially my belief for …healing. I now have strong faith for my healing. (INF2 006)

> My faith has increased and now, I believe that God is real and there is nothing that is too hard for Him to do for me. One day, He will heal me completely. (INF3 004)

> My faith has become so real …and now I am believing God for my total healing. (INF3 005)

Participants' belief in being healed did not exclude being healed of HIV and AIDS. They reported their optimism that since God was able to heal other diseases, He was also able to heal them even of HIV and AIDS. For example, two participants each expressed their new faith in God as follows:

> I believe if God can heal cancer and all other diseases, then God can heal even HIV. I want to trust that he will and will never fail me. (INF5 010)

> Sometimes I used to wonder if miracles are real and can really happen. This because it is rare to hear of cases where people have been healed of HIV. This is not to say that I did not believe in miracles. It is just that my faith was very little. I now believe that God can change any hopeless situation and can heal any disease. Although I am taking ARVs, my faith is increasing. I have been taught that in order to receive my miracle, I must maintain my confession and talk positively all the time. (INF5 011)

Other participants reported how their 'belief' had actually become a reality, having experienced actual healing. Many asserted that they or their children had been healed of various health problems. Asked if they experienced fatigue or loss of energy to the extent that it prevented them from engaging in activities that they wanted to do, a larger percentage reported affirmatively during the baseline (53%) than during the follow-up (22%). Similarly, of those who reported that they felt tired most of the time, a little of the time, or some of the time, the majority were those who reported affirmatively during the baseline (97%) compared to (69%) during the follow-up. For example, one participant testified as follows:

I would feel very tired after walking a long distance. Now through prayers and serious meditation on the Word, it is all gone. (INF5 007)

Some participants who had had problems with balance, when walking or when getting up from a chair, expressed how, this was no longer the case. During the baseline, 71% of participants reported that they experienced problems of balance when walking or getting up from a chair. This is in comparison with 36% during the follow-up study. For example, two male participants each said:

I sometimes would have loss of balance and difficulties with walking or getting up. (INF5 007)

My walking was not balanced as I used to feel dizzy and powerless (INF1 001)

Participants reported having been cured of various other health problems including HIV related ones such as body pains, body weakness, dizziness, headache, high blood pressure, anaemia, sore throat and fits. For example, when asked whether they had experienced a cough or headache, findings show that these problems had reduced from the time of the baseline.

Those who reported they had rarely or sometimes experienced a cough reduced from 75% to 52% during the follow-up. Similarly, those who reported they had rarely or sometimes experienced headaches reduced from 72% to 66% during the follow-up. For example, three male and four female participants respectively, who each testified regarding their improved health said:

> I used to allow every kind of sickness to afflict me opportunistic infections used to hit me a lot…but now after learning of divine healing…I am free and healed. (INF6 008)

> My health has been good from the time I started receiving the teachings. Before that, I experienced headaches, general body pains and heart palpitation. Now I am a free woman. (INF3 001)

> I was anaemic...I have been restored because I now have enough blood in my body. (INF4 003)

> I had sores on my throat but after much prayer I got completely healed. (INF1 008)

> I had a lot of problems, which resulted in high blood pressure, heart palpitations and headaches. As a result of the programme, I no longer have high blood pressure, headaches or heart palpitations. (INF2 002)

> My health was deteriorating rapidly, but it is improving and I have gained good health in the last two months. (INF3 002)

> I am now able to pray for my children, believing God for healing and healing does take place as evidenced through my son who used to suffer from fits. (INF2 008)

Participants reported that as a result of their healing, they were now able to live a normal life and engage in activities that their health problems had prevented them from doing. This included being able to walk or to lift heavy things. Another participant reported how he had earlier been released from work on account of bad health but had been recalled as a result of his improved health. For example, six participants who testified in this respect each stated as follows:

> Physically I am very okay; I can even run, which was not the case before the programme. (INF3 006)

> All is well now. I can walk well, stand and run. It is really amazing what God has done in my life. (INF1 001)

> I used to have very poor health but now there is a change. I can walk without problems and can sing and shout to the glory of God because my health is good. (INF1 004)

I used to frequently feel sick but now I no longer get sick like before. I used to fail to carry a 20-litre container of water and do many house chores, but now I am able to do that. (INF6 005)

I was very sick and unable to work. My body was very weak such that I was released from work. Now, my health has improved greatly and I have been recalled to work. (INF3 005)

I had gone into depression after discovering my status, as it was not an easy thing to accept. Hence my health was negatively affected, but thank God through this programme, I feel like a burden has been lifted off me and I feel stronger health wise. (INF4 004)

Other participants reported having been depressed for various reasons including the knowledge that one was HIV positive, or had gone through divorce, or separation. For example, 3 male and 3 female participants respectively, who each testified in this regard stated as follows:

I had gone into depression after discovering my status, as it was not an easy thing to accept. Hence my health was negatively affected, but thank God through this programme, I feel like a burden has been lifted off me and I feel stronger health wise. (INF4 004)

I was going through a process of divorce the time I first started attending the life transforming seminar. That period was not very easy and took me into depression. However, having surrendered my life to God, I started seeing the hand of God through these tough times. I have seen God restore peace and joy despite going through what I went through. (INF4 005)

I was a very depressed person because of all I was going through. I know with all my heart God has dealt with that depression because of the joy I have now that I never had before. (INF4 006)

I used to feel discouraged but now I have courage and I used to worry a lot, but now I have been changed. I used to feel abandoned but no more and I am no longer feeling depressed. (INF6 004)

I have a lot of faith within me. Before coming to this Seminar, things were not ok, I went through separation with my wife and so there was so much rejection and pain, loneliness and worrying. (INF1 004)

Before I used to have headaches and high blood pressure because of thinking too much as in how I will pay school fees for children. But now I just leave everything in the hands of God and no longer have high blood pressure or headaches. (INF2 006)

5.4.13 Programme's Impact on Emotional Support

Qualitative findings further revealed that the programme had a positive effect on the emotional well being of participants. For example, some participants reported that

although they were still experiencing stigmatization by some of their families, friends and general community members; they felt loved by Jesus and perceived this new friendship as genuine, loyal, and transcending all their personal problems. For example, one male and two female participants respectively, remarked as follows:

> Being HIV positive is not an easy burden to carry because even family members reject you, they discriminate against you. But I have come to understand that there is a friend who sticks closer than a brother and His name is Jesus. (INF5 002)

> The thought that one day, I would no longer be on this earth, brought a lot of fear in my life. So I resorted to drinking. (INF5 010)

> I now feel peaceful and at rest. (INF5 006)

Further, participants reported being free of bitterness and forgiving those that might have wronged them; in particular, those who they perceived had infected them with the HIV. For example, two middle aged female participants reported as follows:

> I have learnt that I need to forget about my past, forgive everyone who has wronged me and who I wronged. (INF5 006)

> This programme has helped me deal with the problem of bitterness, which I have had for over 5 years now. Before the programme, I was very bitter with the man that infected me with the HIV virus. That is why at first, I had wanted to infect as many people as possible. Counselling from the clinic did not take away the bitterness I had against men. (INF5 009)

5.4.14 Programme's Impact on Relationships

The data showed positive effects on the participants' relationships with their respective spouses, family members and other society members within their circle of relationships.

5.4.15 Programme's Impact on Livelihood

The data showed that, in the participants' perspective, the LTS programme had made a difference to their financial and general material well-being in various ways. Responses to that effect indicate that respondents reported that they were financially better off than now than they had been before participation in the programme; Data show various areas of their respective lives were mentioned: some said they had now found a new job; or that their business was performing better; or their creditors were miraculously no longer asking them to pay up; or because they had become self-disciplined, more focused and therefore more prudent in regard to how they planned, budgeted or spent their finances. For some, they were now able to have at least three meals per day.

For example, four males and three female participants respectively, whose financial standing had improved significantly, remarked as follows:

I have now been experiencing better and bigger results financially and materially. (INF6 007)

I have experienced financial and material blessings in my life. (INF6 005)

I have now been experiencing better and bigger results financially [and] materially because I have shifted from doing the same things which used to give me the same [poor] results all my past years (INF6 007)

I have experienced financial and material blessings in my life. I have learnt to focus on the things I can control for me to become what I want to become…I used to have one meal in a day but now we are able to have 3 full meals every day. I used to struggle financially but now I am financially sound and ticking. (INF6 005)

I used to fail to make ends meet in terms of food. Now I eat well because my thoughts about life have been transformed. (INF6 007)

Life is easier now and in terms of livelihood and making ends meet. (INF6 003)

My husband to used to have a big debt and for this reason, he was afraid of staying at home. After prayers, he came back home and the friend never even asked him for the money. (INF2 005)

Some participants' financial well-being was improved by the fact that they had found a job from which they were now earning a steady income. As far as they were concerned, this was as a result of their new way of life, which had been influenced directly by the LTS programme. Other participants who were already in employment reported that they had been promoted to a higher position and they believed strongly this was a direct result of the LTS programme. For instance, two female participants and one male participant who testified regarding an improved sense of well-being, each remarked as follows:

> Financially, many doors have opened in my life and job opportunities have come my way (INF2 006)

> He (my husband) has received promotion at work and can now pray and is able to receive what he wants from God. (INF1 003)

> I have been promoted at work. (INF1 001)

5.5 SUMMARY OF CHAPTER 5

This chapter has presented both the quantitative and qualitative findings that are analysed and discussed in the next two chapters.

CHAPTER 6: ANALYSIS AND DISCUSSION OF RESULTS

This chapter discusses the results of the logistic regression analysis, which show that those who participated in faith-based Life Transformation Seminar (LTS) being the main intervention were *4.1 times* more likely to report having adopted new behaviour or modified old behaviour specifically to live positively than those who did not attend the faith-based seminar.

Similarly, those who participated in faith-based Life transformation seminar were *2.3 times* more likely than those who did not participate in the seminars to report having practiced safer sexual practices. The results of the analysis further reveal that those who participated in the life transformation seminars (main intervention) were more likely to report abstaining from sex than those that did not attend the seminars.

The chapter also discusses the qualitative results, which show that the faith - based Life Transformation Seminar intervention had a significantly positive impact on the participants.

6.1 DISCUSSION

Earlier, it was noted that cross-tabulations were done to find out the nature of the relationship between independent variables and outcomes. Chi-square testing was done in order to find out whether the observed relationships between independent variables and outcomes occurred by chance or whether they were statistically significant. Significance was tested by means of 95 % ($P < 0.05$) and 99 % ($P < 0.01$)

of confidence intervals. The result, in this respect, is statistically and practically significant. Here is how and why.

In this research, with the help of logistic regression analysis, an effort was made to examine further, how far behaviour change is influenced by various socio-economic and demographic factors. The results of the logistic regression models were converted into odds ratios, which represented the effect of a one-unit change in the explanatory variable on the indicator of modifying their behaviour. The odd ratio larger than 1, indicates that those who attended the congregation-based seminar had a higher chance than those who did not attend the seminar in modifying their behaviour. An odd ratio less than 1 indicates that those who attended the seminar had a lower chance than those who did not attend the seminar to have that that behaviour.

The analysis of baseline data at the bivariate level showed that there were no significant differences between participants in the intervention and control groups in behaviour change. But after the analysis of the intervention data, the results of the logistic regression analysis revealed that that the congregation-based LTS was found to be highly significant in determining behaviour change. As noted (in the quantitative Results section of the Study), those who participated in a congregation-based seminar were 4.1 times more likely than those who did not attend the seminar to report having adopted new behaviour or modified old behaviour. The results further indicated that those who participated in the seminar were 2.3 times more likely to report that they had practiced safe sex[1] with their partners than those who did not attend the seminar. Also those who attended the seminar were 1.8 times more

[1] As per definition in Chapter 5, in the context of the current study, this usage is in reference primarily to condom use

likely to report having abstained from sex[2] than those who did not attend the seminar. No significant differences were observed with other socio-economic variables. It is therefore concluded that the intervention programme had a sustained impact on participants in adopting behaviours of abstinence and practicing safer sex with their partners. These findings agree with the hypothesis of the Study.

6.2 Sexual Behaviour And Practices: Functionality of abstinence and marital fidelity

In this section, we focus on **abstinence** and **marital fidelity.** A look at the determinants of sexual behaviour revealed by logistic regression testing (see Tables 18-20) shows significance that is instructive.

For instance, Figure 23R (below) shows that at baseline stage, there were no significant differences between the intervention and control groups. However, at follow-up phase, several significant differences emerged between them. Participants in the intervention group evidenced a significant change in behaviour as they reported having abstained from (pre-marital) sex while others reported having modified significantly their behaviour towards safer sex practices. Specifically, 26% and 51% of respondents reported having abstained from sex at baseline and follow-up, respectively. 74% and 49% of the respondents reported not having abstained from sex at baseline and follow-up, respectively. There was an increase in the percentage of respondents who abstained from sex in the Intervention group and a

[2] Pre-marital and well as extra-marital sex in reference

reduction in the percentage of respondents who had not abstained from sex (pre-maritally) in the control group.This shows that the intervention was effective.

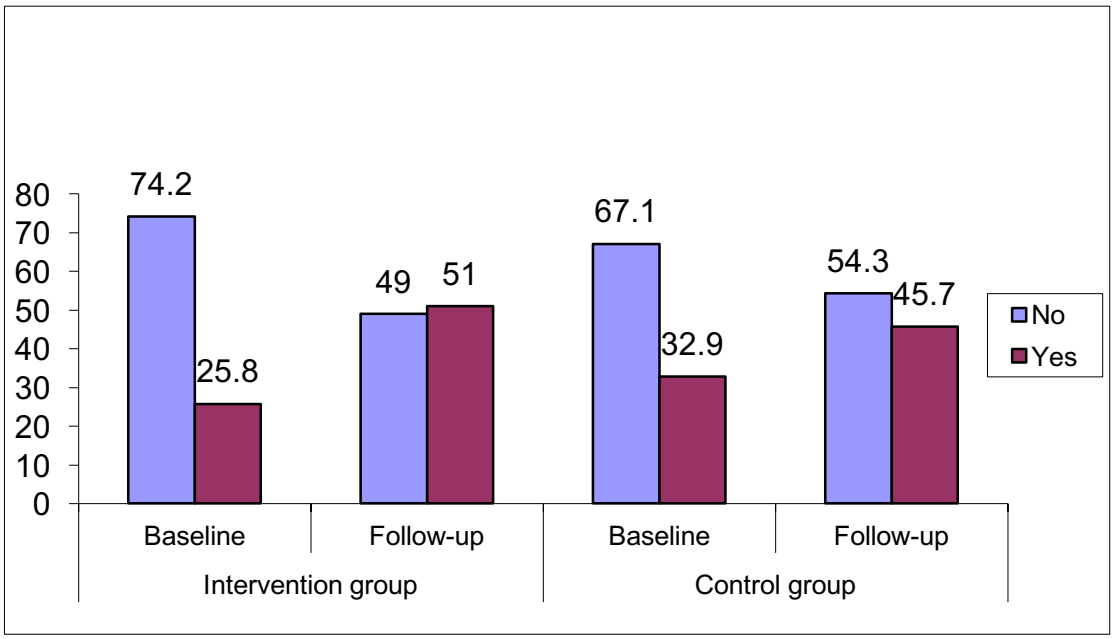

Figure 23R: Percentage of respondents who reported having abstained from sex

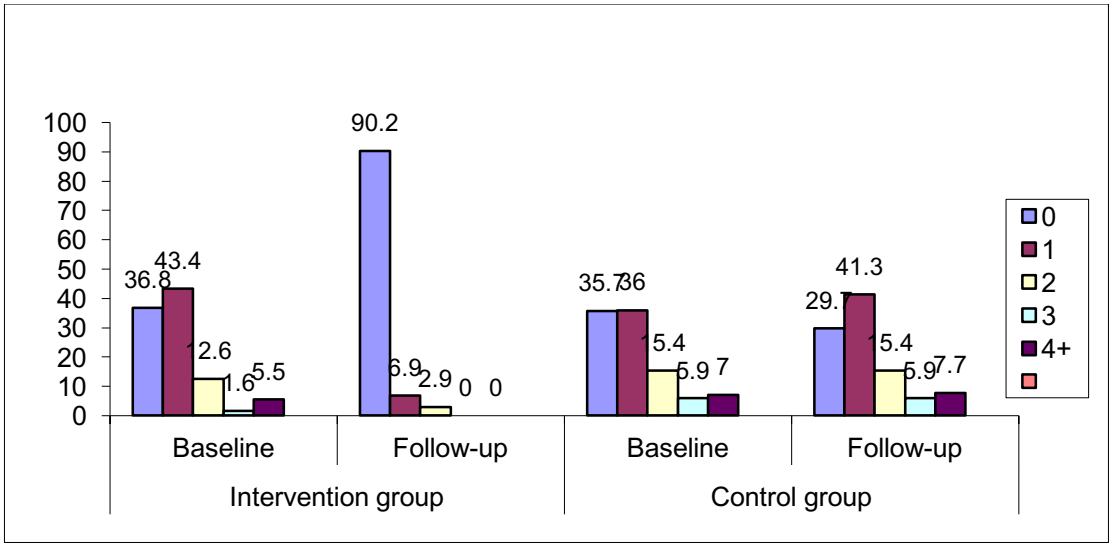

Figure 24R: Percentage of respondents who reported number of people having had sex with some one outside marriage in the past three months

These findings are consistent with the earlier evidence gathered through a study led by David C. Atkins and Deborah E. Kessel of Fuller Theological Seminary, who established as noted in the literature review that attendance at religious services predicts marital fidelity. The study appropriately explores how various dimensions of religious life, including prayer, closeness to God, faith, and religious activities relate to alteration of infidelity practices.

In the early years of efforts to combat HIV, there was a general scepticism regarding the efficacy of faith-based prevention approaches, particularly abstinence. This was largely due to lack of documented interventions and verifiable evidence to demonstrate such efficacy. Between 2003 and 2008, financial resources from the United States of America Government through the Presidential Emergency Plan for AIDS Relief (PEPFAR) assisted the boosting of FBO efforts that resulted in the expansion of programmatic interventions with capacity to document best practices.

The current study is among the first specifically to seek to assess the impact particularly of Pentecostal congregation-based interventions while elucidating on the practical functionality of abstinence and marital fidelity. These preliminary findings suggest that scaling up these interventions holds potential for significant gains towards stemming new infections.

Further, these findings are in consonance with evidence from the last three rounds of Zambia Demographic and Health Surveys (ZDHS). A comparison of the ZDHS of 1996, 2001 and 2007 showed signs that more young people (Females 15-19; Males 15-19 as illustrated in Figure 25, delay sexual debut and remain sexually

abstinent for longer.[3] It is yet necessary minimally, to place this finding against the well-known historical backdrop of early apprehensions that met the promotion of abstinence (and in some cases marital fidelity), both of which approaches gradually came under intense public scrutiny and criticism, as they were repeatedly dismissed as allegedly "non-evidence based and unrealistic." The evidence in reference is immediately below:

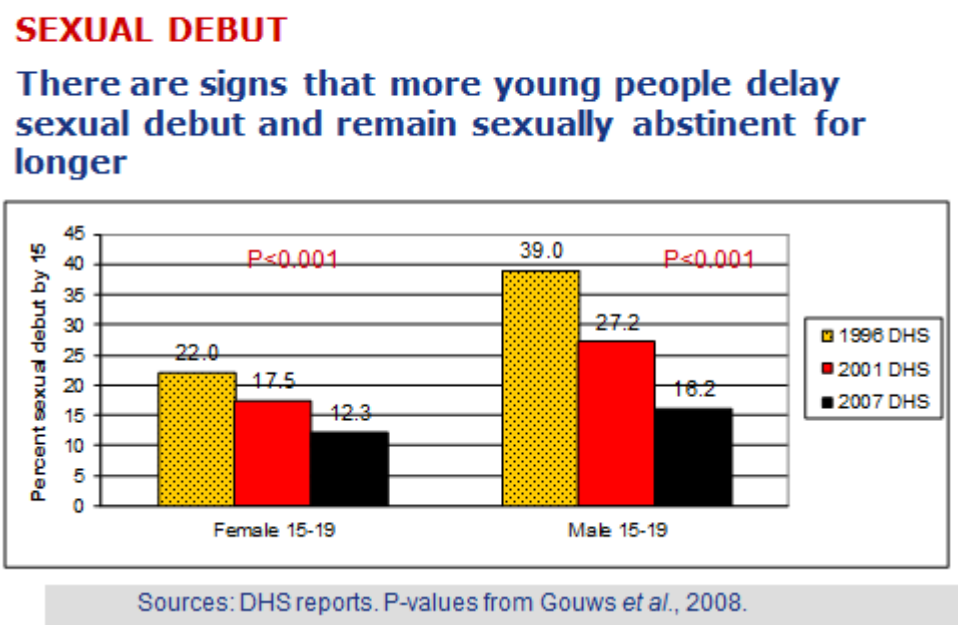

Figure 25: Delayed sexual debut, young people saying abstinent longer

In this case, the above finding lends further credence to the growing body of literature published in some peer-reviewed journals showing that Abstinence and Being Faithful (A&B) behaviours, especially the latter (i.e. mutual marital fidelity,

[3] Zambia Demographic and Health Reports – *P* values from Gouws *et al. 2008*

partner reduction) are among leading factors that impact HIV prevalence and incidence rates at the population level. Evidence from Uganda [4] and Kenya still ranks the strongest at present. Policy and practice must be duly informed by such evidence (Banda, 2004). The significant optimism (figure 26, below) towards the ideal of sexual abstinence as a key measure for AIDS prevention in this regard is well founded.

In an in-depth analysis of data from the 2001-2002 and 2007 Demographic and Health Surveys, Kembo (2013) concluded that there had been significant changes in "selected sexual behaviour and practice and HIV indicators among young people aged 15-24 years." [5] Particularising the first indicator which dealt with *abstinence* among "never-married young men and women aged 15–24 years," [6] Kembo explained:

> This indicator refers to the percentage of never-married young women and men aged 15–24 who have never had sex. The results presented …indicate that overall in Zambia the percentage of abstinence among never-married young men and women aged 15–24 years increased significantly by 15.2% ($p = .000$) and 5.9% ($p = .001$), respectively, between 2001–2002 and 2007. A comparison by area of residence reveals that this increase was only significant among young persons aged 15–24 years residing in urban areas as compared to their counterparts who lived in rural areas. The percentage of abstinence among never-married young men and women aged 15–24 years who resided in urban areas increased significantly by 27.1% ($p = .000$) and 9.3% ($p = .000$), respectively, from 2001–2002 to 2007.[7]

Linking his conclusions, in this respect, to programmatic implications drawn, Kembo posited that the "…delay of sexual debut among young people has been well embraced in Zambia and should continually be promoted and sustained." [8] Further he

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[4] Kirby, Doug. Changes In Sexual Behaviour Leading To The Decline In The Prevalence Of HIV In Uganda: Confirmation From Multiple Sources Of Evidence. Education, training and research (ert) associates. January 1, 2008

[5] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4039133/ Accessed 21 November, 2015

[6] Ibid

[7] Ibid

[8] Ibid

observed that "research has shown that the delay in sexual initiation is an indispensable aspect in HIV prevention programmes (Kembo 2012; Ndubani 2002), adding that "promoting abstinence has been an important strategy that has led to the delay in sexual activity among young people in Zambia."[9] In the same breath, Kembo counselled aptly that "programmes aimed at combating HIV and AIDS in Zambia should deliberately seek to address the higher risk of HIV infection among young women aged 15–24 years relative to their male counterparts."[10]

In the study on Uganda's HIV Prevention success: the role of sexual behaviour change and the national response, Green *et al*. (2006) cited what they rightly termed:

> encouraging findings from places such as Kenya (Kenya DHS, 2003; Green,2003), Addis Ababa (Mekonnen *et al.*, 2003; Shelton *et al.*, 2004) Zambia (Agha, 2002; Bessinger *et al.*,2003; Fylkesnes *et al.*, 2001; Shelton *et al.*, 2004), and Zimbabwe (HAYES and Weiss, 2006), suggest that a comprehensive, behavio[u]r change-based strategy, ideally involving high-level political commitment and a diverse spectrum of community-based participation, may be the most effective prevention approach.[11]

This comparative, evidence opens a window opportunity for the global community to reprioritise sexual behavioural change interventions. This study, as per Figure 25 above, has capitalised on that window of possibility with hope and espouses further as per Green *et al.* summation that "According to modelling by Stoneburner and Low-Beer (2004), behavior[u]r change, particularly partner reduction, since the late 1980s in Uganda appears to have had a similar impact as a potential medical vaccine of 80% efficacy."[12]

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[9] Ibid

[10] Ibid

[11] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1544373/ Accessed 21 November, 2015

[12] Ibid

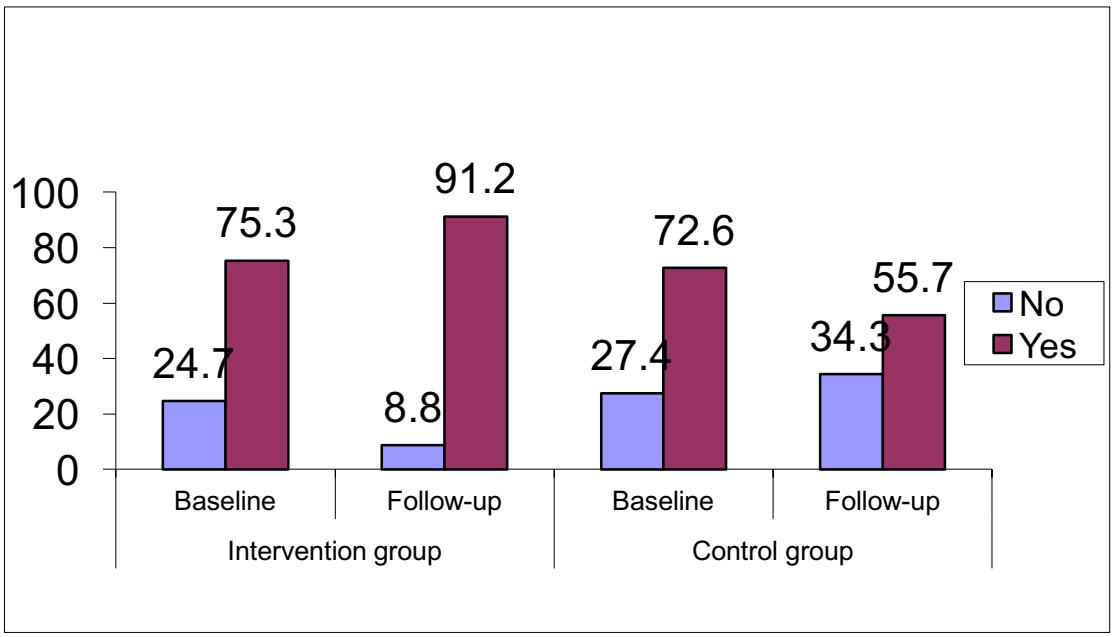

Figure 26: Percentage of respondents who reported abstaining from sex was possible

We turn now to consider marital fidelity**.** In the literature review, Advert and CDC were identified as global entities that, among many, have advocated the ABC approach towards AIDS prevention. The "B" focuses on *Being Faithful* to one sexual partner. In the church congregation circles, this is understood as being *faithful* within the context of marriage. Figure 27R (below) shows that respondents in the intervention group evidenced a significant change of sexual behaviour directly addressing the main research question as well as the subsidiary questions.

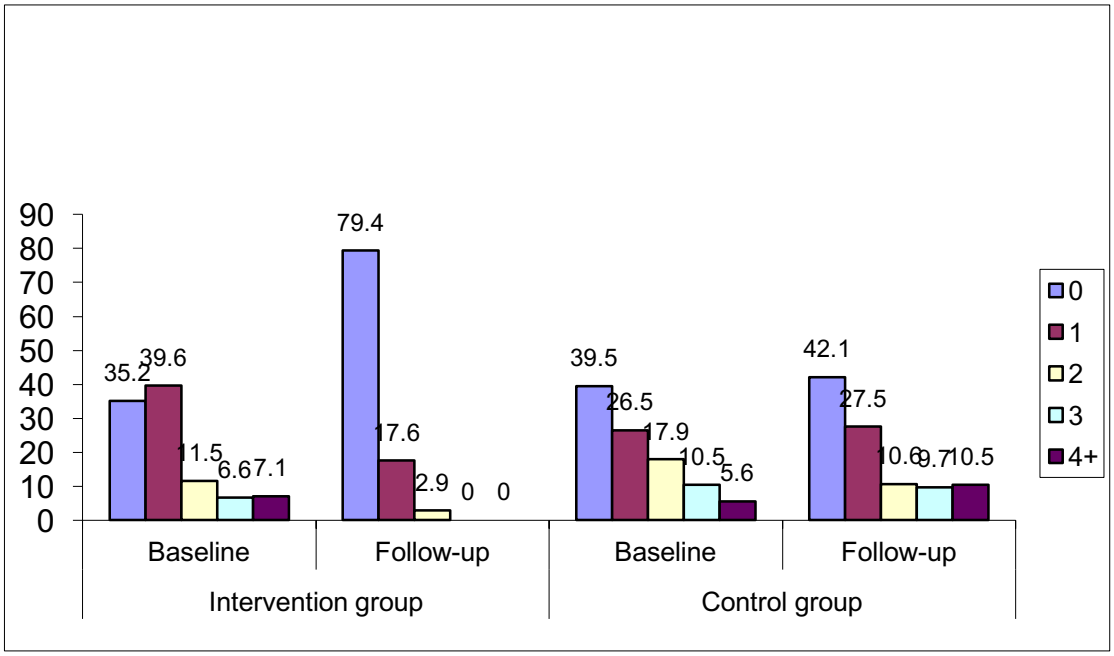

Figure 27R: Percentage of respondents who reported number of concurrent partners they had sex with in the last three months

In this study, marital fidelity is identified as a functional outcome that is able to contribute significantly towards curbing new HIV infections, particularly in view of multiple and concurrent partnership being ranked among the six key drivers of the AIDS Epidemic in Zambia's National AIDS Strategic Framework (NASF, 2011-2015). However, what is the extent of multiple concurrency and its related complexities?

The ZDHS (2007) found that only 12% Females and 24% Males surveyed believed that "*most married men they know only have sex with their wives"*. Only 32% Females and 35% Males believed that "*most married women they know only have sex with their husbands*". It has been noted that MCP behaviours and extramarital affairs are "underreported in surveys, especially by women." Reporting concurrency is also understood to be negatively affected by social desirability or self-reporting bias as per the following comment: *"If I must have another girlfriend, I*

mustn't make it public" (Zambian male, 20-25 years, Longfeld *et al.* 2002).It is worth observing though that the ZDHS (2007) results showed decreases in reported multiple partner frequencies in adults with decreases in the mean number of reported partners in the past year and also decreases in frequencies of extramarital sex in Males and Females. And in youth 15-24, there was evidence of partner reduction. Figure 27 below illustrates the same:

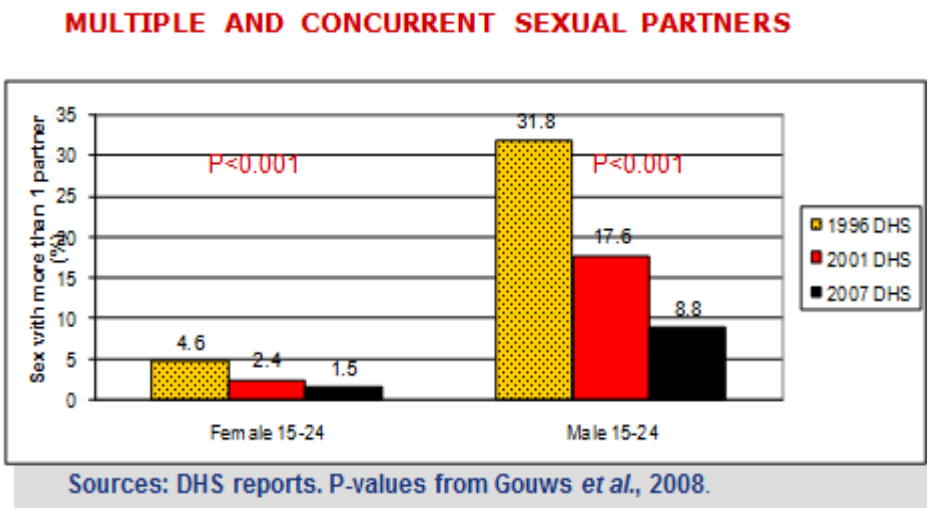

Figure 27: Multiple and concurrent sexual partnerships

Overall, the survey observed that there was a strong positive association between the number of reported sexual partners and HIV infection as per figure below:

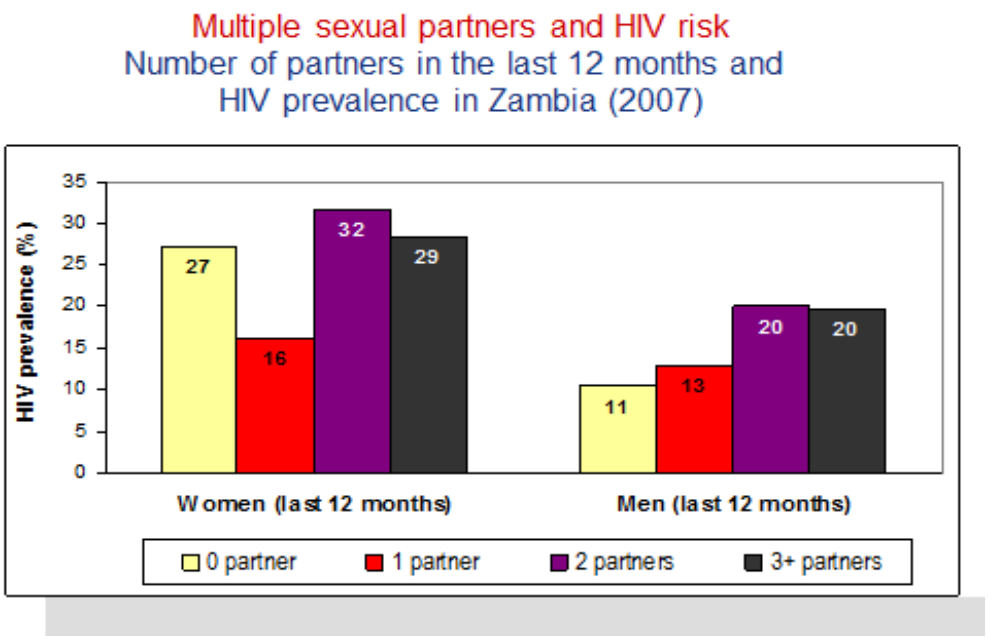

Figure 28: Multiple sexual partners and HIV risk[13]

Noting once again that multiple and concurrent sexual partnerships (MCP) are among the six key drivers of the Zambian HIV epidemic and observing the distribution in the table below, it remains necessary to see MCP interventions as ranking very high on the prioritisation list for ethno-cultural and social factors upon which to anchor long term positive responses to reverse the current HIV trend.

[13] Sources: DHS Reports. P- values from Gouws, *et al*. 2008

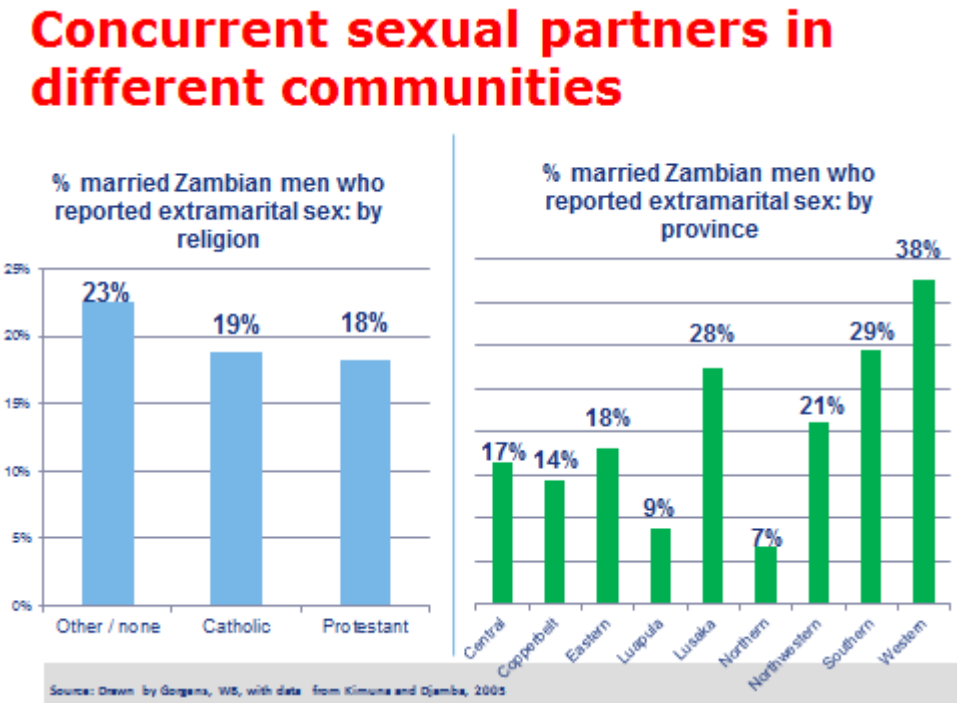

Figure 29: Concurrent sexual partners in different communities

As stated in the Pan African Christian AIDS Network's (PACANet) April 2010 publication on Multiple and Concurrent Sexual Partnerships:

> Epidemiological modelling suggests that even a relatively small reduction in MCPs would break up extensive sexual networks and could significantly slow the spread of HIV in the sexually active population. Various research findings have shown that having concurrent partners greatly increases HIV transmission compared to sequential or serial partnerships because new infections can spread much more rapidly through the sexual network when its members are simultaneously connected. Therefore, the ultimate goal of all HIV prevention initiatives must be to reduce HIV incidence. And to maximize prevention outcomes around MCPs the following two outcomes need to be prioritized: A reduction in multiple and concurrent partnerships– through social and behavioural change. A reduction in the transmission of HIV within multiple and concurrent partnerships as well as within known discordant relationships – including through consistent correct use of male or female condom use.[14]

[14] Banda, Joshua H.K. (*MCP- The Experience of the Church in MCP: The Evangelical Perspective)* in "*Multiple and Concurrent Sexual Partnerships"- A Consultation with Senior Religious Leaders from East and Southern Africa.* Pan African Christian AIDS Network (PACANet), Jane Wambui Rosenow, ed., 2011, pg. 71

In a study bearing evidence from various National Population-Based Surveys on concurrent sexual partnerships and HIV Infection, Mishra *et al*. (2009) established that "men are more likely than women to have multiple and concurrent sexual partnerships."[15] The study, which represents a significant attempt to call attention to the "prevalence and correlates of sexual concurrency, as well as on the association between concurrency and HIV infection at different levels of aggregation"[16] also revealed the following:

> many multiple partnerships in the past 12 months were not concurrent and that, for men, the majority of concurrent partnerships (excluding polygymous marriages) overlapped for less than one year. In the pooled samples for sub-Saharan Africa, urban, more-educated, and wealthier women and men are more likely to have had concurrent partnerships than their rural, less educated, and poorer counterparts. Circumcised men are also more likely than uncircumcised men to have had concurrent partners. Women and men who had concurrent partners were more likely to use condoms than those who did not have concurrent partners;

Whatever the permutations may end up being, a key practical consideration at programmatic and intervention level is to propel initiatives towards partner reduction as that will in turn influence minimization of risk for spiralling of new infections. Shelton (2005) argued that "partner reduction remains the predominant explanation in Uganda's early success story of the then drastically decreased incidences.[17] In an earlier publication, titled "Partner reduction is crucial for balanced "ABC" approach to HIV prevention," Shelton (2004) *et al.* contended that "behaviour change programmes to prevent HIV have mainly promoted condom use or abstinence, while

[15] Mishra, Vinod, and Simona Bignami-Van Assche. 2009. Concurrent Sexual Partnerships and HIV Infection: Evidence from National Population-Based Surveys. DHS Working Papers No. 62. Calverton, Maryland: Macro International Inc

[16] Ibid

[17] Shelton, J. D. (2005). Partner reduction remains the predominant explanation. (Letter) *BMJ* March 9, 2005, http://bmj.bmjjournals.com/cgi/eletters/330/7490/496-a#99730

partner reduction remains the neglected component of ABC."[18] The study is well abstracted as follows:

> The key to preventing the spread of HIV, especially in epidemics driven mainly by heterosexual transmission, is through changing sexual behaviour. Interest has been growing in an "ABC" approach in which A stands for abstinence or delay of sexual activity, B for be faithful, and C for condom use… Although "be faithful" literally implies monogamy, it also includes reductions in casual sex and multiple sexual partnerships (and related issues of partner selection) that would reduce higher risk sex. While most of the often polarised discussion surrounding AIDS prevention has focused on promoting abstinence or use of condoms, …partner reduction has been the neglected middle child of the ABC approach.

Green *et al.* cited "lower levels of multiple partnerships and reduced sexual networks in Uganda compared to many other African countries."[19] The comparative picture is painted skilfully as follows:

> By the mid-1990s, in general Ugandans had considerably fewer non-regular sexual partners across all age groups. Population-level sexual behavio[u]r, including the proportion of people reporting more than one partner, were comparable in Kenya (1998), Zambia (1996) and Malawi (1996), for example, to levels reported in Uganda back in 1988–1989 (Stoneburner and Low-Beer, 2004). In comparison with men in these countries, Ugandan males in 1995 were less likely to have ever had sex (in the 15–19-year-old range), more likely to be married and to keep sex within the marriage and much less likely to have multiple partners, particularly if never married. Strikingly, the proportion of men reporting three or more non-regular partners in the previous year fell from 15 to 3% between the 1989 and 1995 GPA surveys. The latter figure was identical in both that GPA survey and the 1995 Uganda DHS (Bessinger *et al.*, 2003).

Green *et al*. rightly observed that the "reported behavio[u]ral changes [were] consistent with the dominant AIDS prevention messages of Uganda's early response (i.e., 1986–1991), specifically: "stick to one partner," and the ubiquitous "love faithfully" and "zero-grazing."[20]

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[18] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC387490/ Accessed 22 November 2015

[19] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1544373/

[20] Ibid

6.3 SELECTED CASE STUDIES

Although it was not the focus of this research, the qualitative data particularly raised social factors and concerns especially by married men whose had adopted new behaviour of fidelity, the were previously influenced highly by cultural norms that tend to weigh heavily on one sided expectations for a wife to be 'obedient'[21] to her husband. As such, they disclosed that some of them would feel 'pushed away'[22] when they felt conjugal relations were not to their satisfaction. Surprisingly, the males in the discussions admitted they expected their spouses to initiate sex. And when, that did not happen, they 'explored' outside options. The following case studies provide a thick expression of the reality of actual human faces behind findings of any study. They serve to illustrate further, how Zambia's epidemic may be fuelled by other complex ethno-cultural factors for which specific interventions from the church and other FBOs ought to be initiated. We now take cursory review of the following studies:

[21] In-depth Interviews with Informants- Focus discussion groups- July 2012

[22] In-depth Interviews with Informants- Focus discussion groups- July 2012

6.3.1 Kwatu 2008- Attitudes Concerning Sex in Marriage[23]

It was reported in this study that husbands expect their wives to comply with cultural dictates such as not initiating sex, but men also consider 'boring sex lives' at home as push-factors for extra-marital sexual relationships.

6.3.2 Soul City 2008- Attitudes Concerning Extra-marital Affairs

Respondents in this this study actually said "Women are expected to accept their husbands' extra-marital sexual affairs but women who have affairs themselves are condemned." Evidently, these cultural prescriptions not only discourage assertiveness or independence, but also put women at risk of HIV infection.

6.3.3 WLSA[24] 2007- Sexual Cleansing and Widow Inheritance

The ritual involves a woman having sex with a member of her deceased husbands' family to allegedly 'purge the spirit or ghost' of her deceased husband**.** This is usually associated with ***Widow Inheritance***, a practice where a member of the family of the deceased succeeds and marries or inherits the widow.

This has been documented for Central and Lusaka Provinces.[25] The husband's family in this tradition holds that a widow who refuses to be inherited may face severe punishment and rejection. However, it must be noted that if the husband died of AIDS, the man who inherits the widow is definitely at increased risk of HIV infection.

[23] Zambia HIV Response Modes of Transmission Analysis Report -2009

[24] Women and Law in Southern Africa

[25] Women and Law in Southern Africa (WLSA 2007)

With the fresh evidence of the impact and efficacy of congregation-based interventions, Churches have the opportunity to strategize and craft well-informed interventions that could make a tangible difference in the fight against HIV/AIDS.

6.3.4 Alcohol and Drug Abuse

We proceed to discuss the determinants of alcohol and drug abuse. This study sheds immediate light on the potential positive impact that would result from possible scaled-up interventions to minimise social abuse of alcohol and illicit drugs. This is especially so given the vulnerability of Zambian society to new HIV infections due to tendencies towards risky sexual behaviour seldom associated with alcohol and yet the link is real.

In Zambia today, few question alcohol's cultural place or availability. It is observable that what has previously been described as "a mix of powerful intangible social forces – such as habits, customs, images and norms" to a large extent, drives the nation's drinking culture (Draft Zambia Alcohol Policy-DZAP, 2007). Socialisation around alcohol appears to be driven by other equally powerful tangible forces relating to the economic and physical availability of alcohol – such as promotion and marketing, price, outlets, hours of access and service practices (DZAP, 2007).

At present, no Zambian studies are available to provide HIV prevalence figures in groups with different alcohol drinking habits. Regrettably, the relationship between alcohol consumption or drunkenness and HIV status was not specifically analysed in the 2007 ZDHS. However, it was ascertained from the survey report that sexual intercourse under the influence of alcohol takes place, especially in urban

areas. Alcohol use increases sexual risk-taking that includes multiple and concurrent sexual partnership behaviours along with lower condom use.

An existing challenge is also that the availability of reliable data on alcohol consumption in Zambia remains a contentious issue, due to the large quantities of unrecorded (and untaxed) sales. While some data exist on certain harms arising from alcohol misuse, there is very little data on the actual drinking patterns and availability of alcohol, which lead to those harms.

Although annual per capita consumption of alcohol in Zambia (ZDAP, 2007) has been declining steadily from the peak in 1973, at just less than 10 litres of pure alcohol, some social patterns remain a source of grave worry. Even though the little information available says that alcohol intake is now "relatively low, at 3.02 litres of pure alcohol, ranking Zambia 105th out of 185 countries compared by the World Health Organisation (WHO) alcohol consumption is readily available to under age persons. The ZDAP notes that "there is considerable pressure on parents from other adults and young people to supply alcohol, confusing parents as to how best they could prevent and manage the incidence of underage drinking."

Having such a social concern in view, this study elected to include alcohol and drug abuse (Figure 30R) in the survey instrument with the view to learn whether attendance to a congregation-based HIV intervention could alter this social trend that predisposes many persons to new infections resultant from potentially impaired their life choices.

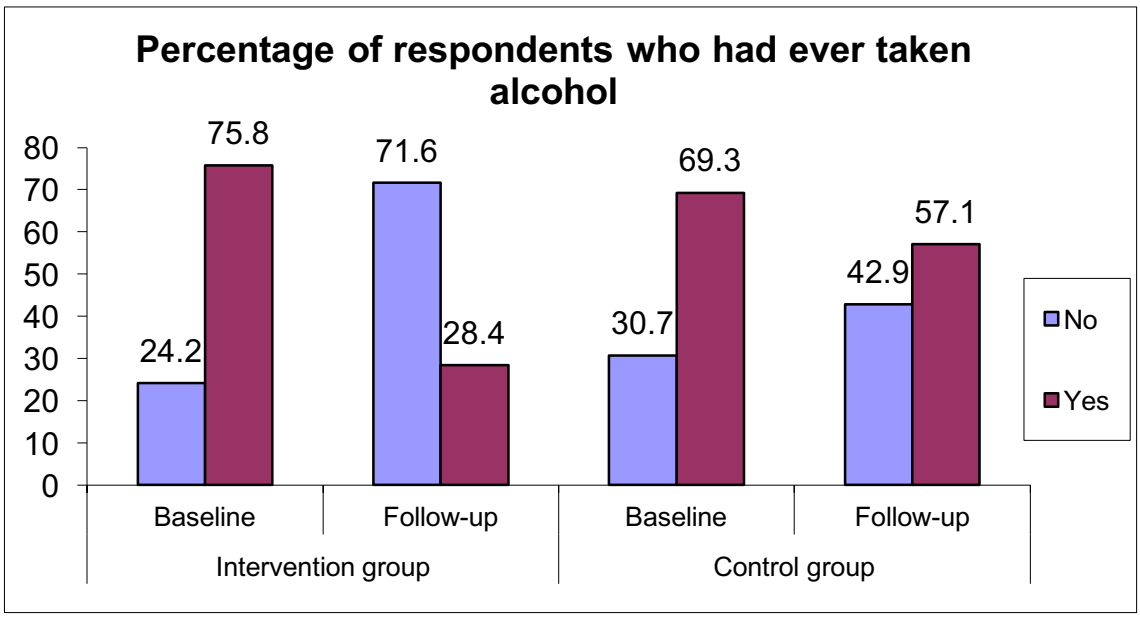

Figure 30R: Percentage of respondents who had ever taken alcohol

Figure 30R shows that at baseline, there were no significant differences between the intervention and control groups in terms of responses recorded. However, at follow-up stage, significant differences emerged between the two groups. Participants in the intervention group evidenced a significant change in behaviour resulting in avoidance of / abstinence from, alcohol. A similar trend appears in relation to participants who reported having specifically modified their behaviour by abstaining from alcohol and refraining from visiting a bar (See Figure 31R below):

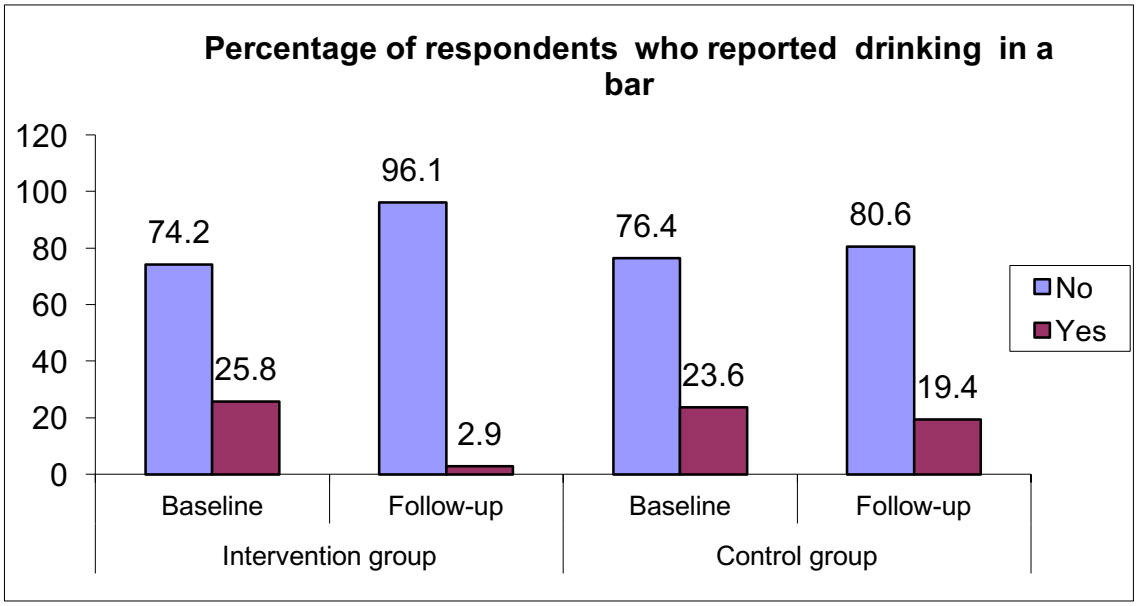

Figure 31R: Percentage of respondents who reported drinking in a bar

In addition to the ways that parents sometimes make alcohol readily available to children, their direct or indirect influence and that of other adults as role models is a critical issue, as young people around them may replicate their behaviours. There is no research fully to explain forces behind these social patterns and pressures and to assess the risks of alcohol use for children and young people.

The afore-going scenario indicates the reality that inconsistent or inadequate data inhibits the development of effective responses. Responding to alcohol concerns, especially in the face of HIV/AIDS requires urgent interventions coupled with ongoing development of the evidence base to inform policy and practice. So far, this study has established that eventual impacts in respondents are tied to the nature of interventions implemented. In the Zambian situation, a comprehensive review of evidence on alcohol consumption and alcohol-related harms and appropriate strategies is necessary for more long range transformation.

To that effect the formation of an Alcohol Regulation Authority has been mooted to help regulate more strictly the current unguarded commercial advertising, sale and distribution of alcohol products. Regulation could extend towards restriction of actual location of (as well as enforcement of laid down operation hours for) bars, nightclubs and drinking places, which are currently numerous in residential communities. What also needs further probing is the economic reliance on the liquor industry for national revenue. What could be some possible alternatives? This matter is addressed in the conclusions and recommendations chapter.

6.4 Further Reflection on The Results

6.4.1 Implementing and Sustaining A Practical Theory of Change

Following an extensive review of literature in relation to: 1) the role that churches in sub-Saharan Africa currently play in contributing to HIV/AIDS-related stigma; and 2) the role that churches sub-Saharan Africa are currently play in *tackling* HIV/AIDS-related stigma, Campbell *et al*. (ibid) concluded among other things, that there is a "pressing need for two forms of research to further actionable understandings in this area."

The first, which is relevant to our current discourse, "relates to the need for more detailed naturalistic case studies of the processes through which some churches, but not others, have organically developed creative and non-stigmatising responses to the challenges of HIV/AIDS." They argued that "indigenous and bottom up responses developed by local groupings themselves are often more likely to be more feasible and sustainable vehicles of social change than actions imposed on

communities by outside professionals and experts." In the latter regard, they particularly refer to NGOs, health promotion bodies and overseas development agencies.

Next, Campbell *et al*. proposed that "where possible, research should be longitudinal, tracking changes in church understandings and responses to HIV/AIDS over time in order to understand the processes" that have at the heart of the transformations or changes being explored. Further, they contended that such studies need to be "explanatory rather than descriptive in nature, underpinned by a *theory of change*, which identifies the processes through which negative social representations of HIV/AIDS, and those affected by it, are sometimes resisted and transformed in ways that lead to greater 'AIDS competence' by church groups."

Andrea Anderson (2005) defined a *theory of change* (TOC) as the product of a series of critical-thinking exercises that provides a comprehensive picture of the early- and intermediate-term changes in a given community that are needed to reach a long-term goal articulated by the community. She suggested the following steps for creating a theory of change: 1) Identify a long-term goal; 2) Conduct "backwards mapping" to identify the preconditions necessary to achieve that goal; 3) Identify the interventions that your initiative will perform to create these preconditions; 4) Develop indicators for each precondition that will be used to assess the performance of the interventions; 5) Write a narrative that can be used to summarize the various moving parts in your theory.

Anderson (ibid) noted that it is difficult to 'trace precisely when the term *"theory of change"* was first used, but a hint at its origins can be found in the considerable body of theoretical and applied development in the evaluation field, especially among the work of people such as Huey Chen, Peter Rossi, Michael Quinn

Patton, and Carol Weiss." [26] She added that these "evaluation theorists and practitioners, along with a host of others, have been focused on how to apply program theories to evaluation for many decades". Further, Anderson notes as follows:

> Weiss popularized the term "*Theory of Change*" as a way to describe the set of assumptions that explain both the mini-steps that lead to the long-term goal and the connections between program activities and outcomes that occur at each step of the way. She challenged designers of complex community-based initiatives to be specific about the theories of change guiding their work and suggested that doing so would improve their overall evaluation plans and would strengthen their ability to claim credit for outcomes that were predicted in their theory. She called for the use of an approach that at first blush seems like common sense: lay out the sequence of outcomes that are expected to occur as the result of an intervention, and plan an evaluation strategy around tracking whether these expected outcomes are actually produced. (Ibid.)

Whilst Weiss was correct in ascribed "common sense" to the genesis of processes that eventually get tracked and recorded as results or outcomes at some stage, it is important to observe that many western organisations that have attempted to partner with churches in the wake of HIV/AIDS have often disdained and dismissed this common sense approach. And Whilst, Campbell *et al*. rightly called for a traceable theory of change, they indirectly register concern for the visible lack of related processes in the churches referenced in their selected studies.

A question must then be asked. Does the lack of a documented process really mean there is no theory of change underlying the HIV interventions in which churches are engaged? Could it be that there might linger, in this noble quest for neatly traceable processes, a potential oblivion to the not-so-obvious, not-so-visible common sense that is proven to be there all along, among the very grass roots communities.

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[26] http://www.theoryofchange.org/what-is-theory-of-change/toc-background/toc-origins/- Accessed 16th March, 2015

Campbell *et al.* said sustainable mitigation efforts (in relation to HIV/AIDS) must grow 'organically', but grow from where or out of what? I contend that it is the very undocumented experiences, the rather unconventional approaches and interventions, the anecdotal details, though often ignored by inquirers, that form the foundation of a wealth of strength, notwithstanding weaknesses, that the churches bring to the table in the fight against HIV.

Campbell *et al*. indicated their espousal of Paulo Fraire's *Pedagogy of the Oppressed* for a proven theory of change. Yet, Richard Shaull wrote the following about Freire in the foreword of the 2005 anniversary edition of the seminal volume:

> Freire's denunciation of oppression was not merely the intellectual exercise that we often find among many facile liberals and pseudo critical educators. His intellectual brilliance and courage in denouncing the structures of oppression were rooted in a very real and material experience, as he recounts in Letters to Cristina: It was a real and concrete hunger that had no specific date of departure.

This is not unduly to criticise Campbell *et al.* (ibid), as it must be noted here, that they indicated a measured limitation of their remarkable study in which they stated:

> As we limited ourselves to the peer-reviewed literature, we may have missed out on important findings identified by non-academic frontline health and welfare practitioners, which are often published in the non-academic 'grey' literature.

This thesis is calling for a paradigm shift that requires re-engagement of the churches with an understanding that there is a sustainable theory of change at the very base of their long-standing acts of documented and undocumented social interventions in the community. We turn to discuss this theory in part at this time.

6.4.2 Spiritually Based Ethical Change

This study has generated evidence regarding significant sexual behaviour change that occurred involving a wide range of key variables following attendance to the Life

Transformation Seminars. The content (See Appendix 11) of the material the various respondents and participants were exposed to at baseline as well as follow-up intervention levels was deliberately designed consistent with the basic foundational Pentecostal biblical doctrines and social teachings, being that the COH model around which the interventions were woven, evolved over time in a Pentecostal congregation, the Northmead Assembly of God Church.

It is now established increasingly in Pentecostal studies that the adoption of the Protestant moral ethic, which involves the promulgation of principles of hard work, frugality and diligence as a "constant display of a person's salvation in the Christian faith,"[27] forms a practical base for a one's personal morality. At the heart of any spiritual experience is an evident ethical change. Personal morality, which must be distinguished from mere social change, lies at the foundation of this prospective change. In a review of David Martin's *Pentecostalism: The World their Parish,* Peter F. Althouse (Pneuma Review, 2005) suggested, "in conversion, a personal transformation occurs in which moral relativism and self-indulgence are rejected in favo[u]r of marital faithfulness, moderation and responsibility."

Martin (2001) argued:

> Pentecostal conversion contrasts helplessness with empowerment, in which people without material wealth gain equality and worth. Like Latin America, women are encouraged to participate in leadership and are encouraged to take pride in their achievements. Church offers a place to find stable husbands who are peaceable and respectful. Pentecostals are encouraged to become individuals, thereby loosening traditional family ties.

The dynamic particularity herein is deeply rooted in the biblical origins of Pentecostalism which show that the very essence of the promise of the Holy Spirit by

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[27] www.google.com/webhp?sourceid=chrome-instant&ion=1&espv=2&es_th=1&ie=UTF-8#q=protestant%20work%20ethic&es_th=1 Accessed 14th May, 2014 & 17th March, 2015

Jesus Christ, the founder of the Christian Faith, was that His disciples (then and now) as per New Testament narrative in Acts 1:8 would be spiritually empowered to effect global ethical impact.

Luke, the biblical author of the book of Acts, wrote as follows:

> But you will receive power when the Holy Spirit comes on you; and you will be my witnesses in Jerusalem, and in all Judea and Samaria, and to the ends of the earth.

A good while prior to the promise in Acts, Jesus, through what has come to be known as the *great commission* in the gospel narrative, gave the following abiding command:

> **18** All authority in heaven and on earth has been given to me. **19** Therefore go and make disciples of all nations, baptizing them in the name of the Father and of the Son and of the Holy Spirit, **20** and teaching them to obey everything I have commanded you. And surely I am with you always, to the very end of the age.

The very nature of Pentecostal Mission today motivates its followers to see themselves inherently as seeking personal ethical transformation as part and parcel of daily life. This is not an additive, rather an integral part of the heart of the gospel message. It derives directly from the 'manifesto' in Jesus Christ's announcement at the commencement of his earthly ministry. The ideals of this teaching are now well developed as a central part of Lucan pneumatology[28] (Luke 4:18- earlier referenced) in which Jesus announced "*the good news*…" and ... *the year of the Lord's favo[u]r."*

In calling attention directly to the "good news to the poor", "freedom for the prisoners… recovery of sight to the blind and letting the oppressed go free…", Jesus made clear a new day had dawned on his hearers. Jamieson *et al.* explained that

[28] Pneumatology: The branch of Christian theology concerned with the Holy Spirit. Also, the term comes from two Greek words, namely, *pneuma* meaning, "wind," "breath," or "spirit" (used of the Holy Spirit) and logos meaning, "word," "matter," or "thing." As it is used in Christian systematic theology, "pneumatology" refers to the study of the biblical doctrine of the Holy Spirit. Generally this includes such topics as the personality of the Spirit, the deity of the Spirit, and the work of the Spirit throughout Scripture. (https://bible.org/seriespage/4-pneumatology-holy-spirit)

"Jesus select[ed] a passage announcing the sublime object of His whole mission, its divine character, and His special endowments for it." They noted that Jesus' message was:

> Expressed in the first person, and so singularly adapted to *the first opening of the mouth* in His prophetic capacity, that it seems as if made expressly for this occasion. It is from the well-known section of Isaiah's prophecies whose burden is that mysterious "SERVANT OF THE LORD," despised of man, abhorred of the nation, but before whom kings on seeing Him are to arise, and princes to worship.[29]

The nature of dynamic, personal moral change proposed here and which to this day is expressed through millions of Jesus' followers, invariably results in social and moral order. Meaning, at the very heart of the gospel message is the ethical agency that produces transformation.

Robert Woodberry's extensive research on "*The Missionary Roots of Liberal Democracy"* (American Political Science Review Vol. 106, No. 2 May 2012) proves the significant social impact of the gospel message propagated faithfully through the efforts of early Protestant missionaries. Applying what took place then to the current norm, Woodberry's rigorous work concludes that:

> Conversionary Protestants (CPs) heavily influenced the rise and spread of stable democracy around the world. CPs were a crucial catalyst initiating the development and spread of religious liberty, mass education, mass printing, newspapers, voluntary organizations, and colonial reforms, thereby creating the conditions that made stable representative democracy more likely, regardless of whether people converted to Protestantism. Moreover, religious beliefs motivated most of these transformations. Statistically, the historic prevalence of Protestant missionaries explains about half the variation in democracy in Africa, Asia, Latin America and Oceania and removes the impact of most variables that dominate current statistical research about democracy. The association between Protestant missions and democracy is consistent in different continents and subsamples, and it is robust to more than 50 controls and to instrumental variable analyses.

This global research demonstrated empirically the transformative power of the gospel message over a wide range of social contexts. The findings of the current study reveal similar impact and therefore confirm Woodberry's conclusions, given

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[29] Jamieson, R., Fausset, A. R., & Brown, D. (1997). *Commentary Critical and Explanatory on the Whole Bible* (Lk 4:18–19). Oak Harbor, WA: Logos Research Systems, Inc.

that the interventions employed and investigated centred on the gospel message and noting particularly, the significant positive changes represented by the key variables and social indicators observed from both the quantitative and qualitative results herein. It is reasonable to conclude also that the fertile environment of congregation-based interventions, nurtures potential for long lasting transformative behaviour change that positively impacts the well being of society.

Take, for instance, the finding in Figure 32R (below) showing a significantly diminished sense of seeing HIV/AIDS as a punishment from God demonstrated by participants.

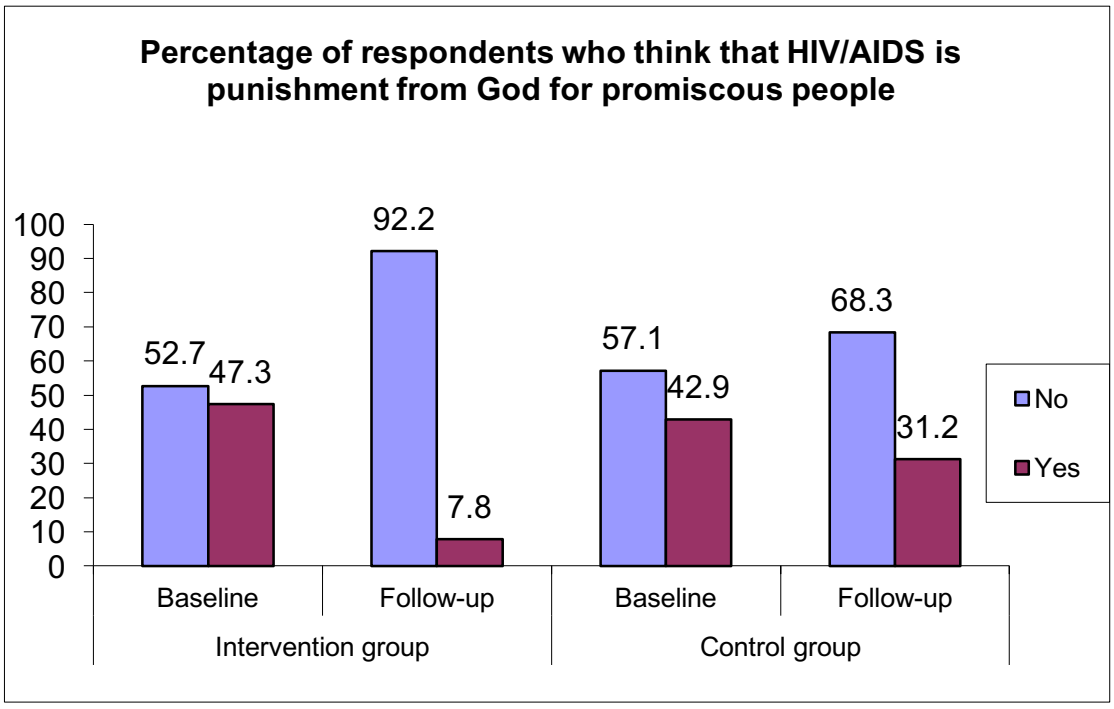

Figure 32R: Percentage of respondents who think that HIV/AIDS is punishment from God for promiscuous people

At baseline, 47% said they believed AIDS was a punishment from God for promiscuous people while 52% were non-affirmative. This range was quite comparable to that of the control group as well. However, at follow-up stage, a significant change was noticeable in the intervention group where 92% were non-affirmative whilst a dismal 7.8% said they still believed AIDS is punishment from God upon promiscuous persons.

By comparison, the range in the control group only adjusted minimally, granting plausibility to the fact that the intervention whose content was mainly the Pentecostal gospel message, catalysed significant impact on the participants. This is further confirmed by the testimonies recorded in qualitative findings as the hypothesis was tested in three other COH sites that yielded similar results.

Based on these and other findings, we can conclude that behaviour change interventions aimed towards HIV/AIDS prevention stigma reduction and impact mitigation efforts by the churches are not only feasible, but also replicable, scalable and sustainable. In the long run, that is what will turn the tide of the epidemic, particularly in Sub-Saharan Africa where most countries are grappling with a generalised and mature disease, which has assumed pandemic proportions.

Since the churches are being sought for sustainable delivery of life saving interventions, it is necessary to explore the challenges and impediments they face in the global arena. One such major challenge the church faces is the promotion of sexual liberalism by many western AIDS agencies. However, before that is tackled, a brief look at the under-pinning conventional public health approach to AIDS prevention and the preliminary points of variance with the faith-based approach.

The contrast with the basic public health approach, as popularised today, is that while it is to be applauded for showing the importance of raising public

awareness and increasing levels of knowledge through sex education and provision of information on AIDS as an epidemic, the attempt to highlight safer sexual behaviour options often tilts rather unguardedly into the direct and indirect promotion of sexual liberalism. In so doing, the conventional public health approach may tend to undermine and weaken moral agency of individuals and whole societies.

6.4.3 Battling with Sexual Liberalism

On July 25, 2012, the Washington Post carried a lead story with the following headline- *"Conservative Christians Working on HIV/AIDS See Burden of Sexual Liberalism"*. Part of the article written by Jabbin Botsford, had the following caption-

> A room full of prominent development, health and faith leaders listened and then clapped politely as a leading Zambian evangelical pastor told the Georgetown University-hosted conference that African nations work with Western non-governmental organizations (NGOs) has "had a downside." That downside, said Bishop Joshua Banda of the Assemblies of God, is the pro-choice "slanted manner" of health outreach.[30]

I was on a panel discussion at a Faith-based AIDS Summit (on the side lines of an International AIDS Conference) with three high profile individuals namely, Rajiv Shah, Administrator of the United States Agency for International Development (USAID), Lois Quam of the United States Department of State and Rick Warren (top American Evangelist) of Saddleback Church. Children's AIDS Fund, Catholic Relief Services and World Vision jointly convened the meeting. We were each allocated a topic to deliver in 5 minutes. My topic was "*The Role of the*

[30] http://www.faithstreet.com/onfaith/2012/07/25/conservative-christians-working-on-hivaids-see-burden-of-sexual-liberalism/10197 Accessed 26th July, 2012 & 15th March, 2015

Faith Community in Leveraging HIV/AIDS Work For the Health of the Whole Person - A Zambian Perspective".

My first of four slides in the presentation introduced the following three areas and ways which, I explained, the Zambian Faith community was utilising to leverage HIV/AIDS for the health of the whole person: 1) Provision of treatment and care services in health institutional settings, owned and run by the faith community (The church in Zambia has had a well acknowledged legacy and back drop of Home-based Care initiatives since the early stages of the AIDS epidemic); 2) Advocacy activities for holistic health care provision targeting the whole person; and 3) Increased community links through massive volunteerism within the churches. These volunteers personally and consistently reach families in various communities where churches are located. As a result, robust and sustainable rapport is developed with needy families. It becomes like an 'open door' into people's hearts.

On the second slide, I highlighted a challenge, namely, a clash between the faith approach and the conventional public health sexual reproductive health rights approach. The clash is inevitable because of the variance that exists between the two approaches. I then proceeded to the third slide to illustrate the point by narrating an incident in Zambia where a named large international NGO (headquartered in the West) had been compelled by the Ministry of Health to withdraw from a rural province of Zambia where it had been operating for some time. This was on account of the fact that the said INGO allegedly conducted 490 illegal abortions on young girls, on the pretext that the girls in question had had 'unwanted' pregnancies. The organisation in question was reported to have conducted the abortions as part of a routine campaign on adolescent sexual reproductive rights. They claimed it was the girls' social right to access the said abortion services

On the third slide, I argued that this 'rights' or 'medical' only approach was a category error on the part of the INGO because in Africa generally, and Zambia in particular, the first point of call for a young girl who happens to get pregnant unexpectedly, is her family. Granted, she may be 'chided' initially by the family for breaking chaste tradition or simply failing to uphold values, including abstinence from premarital sexual involvement. However, in the final analysis, the family will rally around her and encourage her to keep the pregnancy until she is able to safely deliver. Much like what the conservative Christian view holds, the acceptable norm in the majority of cultural settings in Zambia is *pro-life* rather than *pro-choice*. This is enshrined so deeply in Zambian society that the Ministry of Education has enacted a policy provision for young girls to still return to school if ever they got interrupted due to an unexpected pregnancy. An unexpected pregnancy does not necessarily become 'unwanted'!

In that vein, one can understand the gravity of the matter in attempting to run a *pro-choice* campaign in such a cultural setting. My point on the panel therefore was to indicate that it was culturally insensitive for INGOs to promote reproductive sexual health rights in total disregard of the norms of local people on the ground. I argued that the impunity with which these approaches are promoted in both rural and urban settings is morally disrespectful and inappropriate. I concluded that if mutual respect were not the basis for sharing of global resources in the health fraternity, it would be best for donors to keep their funds. The applause that followed took me somewhat by surprise. However, therein commences our discourse on the battle with sexual liberalism in the wake of the global efforts to curb the spread of HIV/AIDS.

Launched in 1999, LoveLife is a campaign said to have been South Africa's largest national HIV prevention initiative for young people, which combined a

"sustained high-powered campaign with nationwide community-level outreach and support programmes to promote healthy, HIV-free living among South African teens."[31]

However, in a critical review of the program, Kylie Thomas (2004) noted that LoveLife's highly visible campaign may not have achieved its intended AIDS prevention goals "as it obscure[d] rather than address[ed] the issues that shape[d] gendered identities and determined the course of the epidemic in South Africa…" AIDS Practitioners from Port Elizabeth interviewed said the campaign, despite having been heavily funded, directed its energies towards promoting sexual rights and liberties of young people than positively combating the AIDS Pandemic.[32] Rena Singer [33]of the Mail and Guardian (n.d.) wrote:

> The same is being asked of many of LoveLife's other Aids-prevention programmes: a television show that flew seven young South Africans to destinations around the world; a journey to Antarctica for another half-dozen youths; and an advertising campaign that has left many South Africans confused. LoveLife maintains that its controversial and unorthodox campaign is designed to make teens more positive and future-focused under the assumption that these qualities will lead them to act more responsibly and avoid exposure to HIV. But after more than five years and R780-million—more than half of it from the Kaiser Family Foundation and other non-profit organisations in the United States—the HIV infection rate among young South African teens remains disturbingly high. About one in 10 teenagers is HIV-positive and about six million people are infected.

Love Life Switzerland[34] is even more illustrative of the sexual liberalism approach as its official website, along with a prominent 2014 *Love Life* campaign banner, features the following "love manifesto":

> I love my body. That's why I protect it.
>
> To enjoy life, I need my body. I protect it from sexually transmitted infections like HIV: if I'm single, cheat on my partner or if a relationship has just ended, I use

[31] www.lovelife.org.za/corporate/about-love life Accessed 17th March, 2015

[32] Personal interview with AIDS practitioner- 2013

[33] (http://mg.co.za/article/2005-08-24-is-lovelife-making-them-love-life- Accessed 13th March

[34] http://www.lovelife.ch/en/campaign/archive/the-models/ Accessed 17th March 2015

> condoms and play by the safer sex rules. In a faithful relationship, after getting ourselves tested, we can stop using condoms.
>
> I have no regrets. And I'll keep it that way.
>
> Mostly you don't regret what you do, but what you don't do. Whether it's an adventure, talking to someone – or safe sex. But I make sure I can always say: I have no regrets.

Another opening message:

> I LOVE MY LIFE. I LIVE IT TO THE FULL. I live as I please and love whoever I want. After all, I only have one life. It's up to me whether I enjoy it or not. I make my own choices and take responsibility for them

Here is how the site opens:

> The new love life campaign, "no regrets", does just what it says on the *tin: it's all about joie de vivre and worry-free sex*. The campaign shows that enjoying life and your body needn't cause you worry – because if you keep yourself safe, you won't have any regrets." The love life manifesto sums up the message of the campaign. Anyone who says yes to the love life manifesto also says yes to themselves – and can enjoy their life and their body without any regrets.

After the above the message, a number of pictorials follow. Let me attempt to describe them: first an explicit picture of a man and woman in a foam filled bath-tub, in each other's arms (with foam all over), leaving the imagination to guess what else could go on. Next picture, right below, is a video, ready to run – (play/ pause option in place). The scenery has a half dressed young lady sitting on the edge of the bed with both hands near the mouth- somewhat tightly clasped against her cheeks (sort of surprised at something she has just sighted! Her eyes are in the direction of a partially undressed gentleman, whose trousers and underwear are lowered down to some where below the knees, as he appears to be advancing towards her.

So could this be the new face of AIDS prevention or what? The point is clear: Sexual liberalism has taken over a good segment of the initially well-meant public health message.

In a riveting chapter titled "how the global AIDS response went wrong,"[35] Green and Ruark (2011) rightly diagnose the heart of the problem with some aspects of the global AIDS response as that of "mistaken priorities." Here is an example they register:

> "Thus, the first experts in AIDS prevention, mostly gay men and members of the family planning community, agreed about the priorities and guiding values of AIDS prevention. Relying on the triumvirate of condoms, HIV testing, and drugs (for treatment of STIs and later HIV) avoided awkward, thorny issues of changing (or restricting) sexual behaviour. If harmful consequences of sexual behaviour could be mitigated or prevented through medical and technological solutions, there was no reason to address sexual behaviour itself. A risk-reduction approach had seemed to work among Western MSM, although how well it worked is now in question (Stoneburner and Low-Beer 2003), and indeed HIV infections among U.S. MSM are today on the increase. But a risk-reduction approach already had the allegiance of the U.S. MSM"

The assessment above illustrates in one sense the key challenge of Western social policy, which is essentially based on a form of radical moral relativism, whose negative impact is apparent globally. It is a moral, ethical failure with adverse implications that permeate beyond the health sector into the socio-economics. It is a dilemma. In the concluding chapter, I suggest an alternative to this dilemma.

It must be noted though that the sexual liberalism battle is not just waged by non-religious or secular entities *per se*. There is a society called *Liberated Christians ("Cyber swing and Polyamony Resource Center and Other-centered sexuality")* with an address in Phoenix Arizona, USA, which has a blog where one of the most recent postings reads: "*Abstinence and the purity propaganda can harm Youth."*[36] One of

[35] Green, Edward, C and Ruark, A. H. " (2011). AIDS, Behavior, and Culture: Understanding Evidence-Based Prevention

[36] www.libchrist.com/index.html Accessed 18th March, 2015

their key banners on the official website indicates that they promote positive intimacy and sexuality including non-monogamy or polyamony.[37]

One other front banner on the site says this society is involved in "exposing false traditions of sexual repressions that have no biblical basis" and so forth. Unlike *Love Life,* there appears to be no direct mention or reference to HIV/AIDS. However, it is a typical illustration of the complex social matrix Western funders and programmers have to contend with in the quest to deliver life saving interventions. The church needs to partner credibly with key stakeholders and service providers in the global AIDS fight so that its strengths can be leveraged and the global community can benefit from its values.

The United Nations' Human Development Report (HDR, 2011) stated: "Sustainability is inextricably linked to basic questions of equity — that is, fairness, social justice and greater access to a better quality of life." I argue that these questions of equity, fairness and social justice are not executable unless the basic values of beneficiary populations are regarded appropriately. Many a faith-based organisation in donor-aided countries has enormous comparative advantage and knowledge to combat religious extremisms that could easily be an impediment to legitimate efforts to combat AIDS. However, they have to be engaged more resourcefully by funding agencies to enable the positive deployment of comparative strengths they possess even though they may not fit in the conventional or traditional public health approach.

[37] Polyamony is the philosophy or state of being in love or romantically or even sexually involved with more than one person at the same time. This is usually with the full knowledge or consent of other partners involved.

6.4.4 How Abstinence and Marital Fidelity Function in Congregation-based Interventions

We have established so far that the theory of change at the heart of the interventions under investigation in this study is the Pentecostal gospel message, which takes a holistic look at life. Even though, as earlier stated, the aim of the study was not to convert participants, the incidental enquiries emerging during the intervention were surprisingly significant. Equally intriguing were the direct questions on HIV which was nowhere mentioned in the LTS materials taught, as the content was biblically based. It will be recalled though, that the Focus group discussions did provide for direct discussions of HIV related issues within the designed discussion tools.

In the New Testament biblical text of Philippians 2:13, the Apostle Paul wrote: *"for it is God who works in you to will and to do of his good pleasure."* Participants' testimonies, as recorded in qualitative data of the study, freely attributed their improved sense of well being to, in their view, the divine power of God.

Apart from divine motivation which participants in the intervention cited as the principal ideal which catalysed their choice of abstinence or marital fidelity in respective circumstances, a sense of communal responsibility and accountability to family members (particularly a spouse, where applicable), and the role of church-mates all appeared significantly instrumental to many of them. The qualitative evidence particularly showed that the spiritual, emotional support received from those around the sero-positive person helped them to sustain their commitment. It became fairly reasonable to deduce that abstinence or marital fidelity and any other behavioural values these persons committed to became sustainable as a result of the

gospel of the Lord Jesus Christ which they had embraced, prior to or incidental and subsequent to their enrolment in the intervention group.

Thus, in the context under reference, abstinence or marital fidelity was seen as going beyond being a mere program. It became and it is a life style that one is motivated to maintain since they see the immense personal benefit to their respective lives.

This finding is instructive in that some past attempts to implement these initiatives have not placed sufficient emphasis of the evident holistic and communal aspects. In some instances, referencing bible norms has been dismissed, particularly by some Western entities that have regarded it mere religious propaganda and/or moralisation of the AIDS response.

In the interventions implemented by COH and investigated during this research, central biblical concepts covering the Christian perspective about sexuality, which is anchored on chastity are discussed exhaustively. It is around this model that abstinence from pre-marital sex is taught and which includes discussions on healthy relationships between boys and girls. In this vein, the value of virginity until marriage is promoted and fidelity in marriage affirmed.

The Study showed, particularly through the focused discussion groups, that adolescents and youths could be open to discuss sexual matters once trust is developed. Conventional public health approaches have tended to raise apprehensions among religious leaders mainly as a result of over-emphasis on sexual reproductive rights, as it is alleged that the churches maybe stifling individual choices of young people.

Commenting on individual choices and rights as espoused conventionally in the public health sector, Professor Ojo M. (2005) observed that:

> Sexual rights, broadly speaking, include the ability to maintain personal preferences regarding whatever ways one exercises his or her sexual feeling in order to attain a high standard of sexuality including the pursuit of a satisfying safe and pleasurable sexual life and the decision to enter into sexual relations and marriage willingly, within this premise. Each man and woman determines what is best for him or her regarding sexual expression.

However, he argued that the Christian position on the other hand:

> Tends to moderate individual choices with the insistence that personal choices must be made within the context of the group tradition and expectation. While affirming sexual health within the premise of its theology of life, the church teaches that sexual rights must be exercised in a very responsible manner… the evangelical position does not regard any of the biblical regulations it upholds as curtailing members' freedom of choice. The evangelical position is that these regulations are promoting a keen awareness of the responsibilities attached to whatever choices are made in the manner one exercises one's sexual expression.

Ojo (ibid) pointed out that the evangelical position actually considers scripture verses like "Genesis 2:17 and Deuteronomy 30:15-20 as clearly affirming individual choice to obtain life and to pursue happiness." He explained that:

> In these verses, the good and right ways are brought near and plainly revealed. The difference from the secular freedom is that the Bible and Christian churches often place before Christians the knowledge of good and evil that will enhance whatever choice is made. The Bible gives freedom of choice but there are always consequences. The scriptures warn of direct consequences in making a wrong choice. Accordingly, good Choices result in divine blessing, happiness and total well being, while wrong choices bring untold misery. Although, contemporary human rights may question this coercion to Choose good, i.e. to tow the conservative position on controlled sexuality, evangelicals insist that this is the only way to empower individuals to experience well being.

Based on this study, the COH interventions have proved a high level of impact and demonstrated a model for robust and practical functionality of both abstinence and fidelity related activities to prevent new HIV infections. A reflection on participants' own testimonial remarks gives credence to the notion that on average, people seek a high degree of well-being and satisfaction in human relationships.

Among married respondents, who committed freshly to exclusive sexual faithfulness to their respective spouses, one more male and three female participants

respectively, who previously had had multiple sexual partners, each reported as follows:

> I used to have other partners beside my wife, but now I have decided to stick only to my wife and no other partners. I never used to be faithful before but now I am able to; especially that I am a married man. Now I am 100% faithful to my wife. (INF2 001)
>
> Before attending this life transforming seminar, I used to have extra marital relationships and thought all was well…I had many boyfriends but not anymore. (NF1 001)
>
> Faithfulness is now the key to my marriage …I will now stick to my husband for better or for worse. (INF1 008)
>
> I never believed in one love or in having only one faithful partner. But now, I understand. (INF1 004)

The study has also demonstrated the actual operationalisation levels the interventions would require.

6.5 SUMMARY OF CHAPTER 6

This chapter has discussed the results of the quantitative data which, based on logistic regression analysis, show that those that participated in faith-based Life Transformation Seminars (main intervention) were *4.1 times* more likely to report having adopted new behaviour or modified old behaviour specifically to live positively than those who did not attend the faith-based seminar.

Similarly, those who participated faith-based Life Transformation Seminar were *2.3 times* more likely than those who did not participate in the seminars to report having espoused safer sexual practices. The results of the analysis further reveal that those that participated in the Life Transformation Seminars (main intervention) were more likely to report abstaining from sex than those did not attend the seminars.

The chapter also bears illustrative elucidations that confirm the findings as having direct positive bearing on the main research question thereby confirming that ***a person's sexual behaviour is influenced by their attitude and behaviour towards God and*** *that* attendance to congregation-based HIV/AIDS programmes could cause a change in a person's sexual behaviour. The illustrative elucidations address important determinants related to abstinence, marital fidelity (in light of the challenge of multiple and concurrent sexual partnerships) and the role of alcohol and drug abuse in the Zambian context of the massive multi-sectorial efforts to defeat HIV/AIDS.

Also covered in this chapter is a proposed model of implementing and practicing a theory of change, which in the case of this study is the application of the biblical gospel message. It is emphasised that spiritually based ethical change is a preferred value in non-Western contexts like Zambia and that there is need for more respectful partnership leveraging between North and South. Further, the chapter highlights the complex social and ethical challenges dogging the AIDS policy arena in the wake of aggressive sexual liberalism.

The chapter has also explained the churches' key comparative advantage with morally based interventions such as abstinence and marital fidelity, showing how they function practically and illustrating their potential as model interventions that are replicable and scalable.

CHAPTER 7: IMPLICATIONS FOR CHURCH CONGREGATIONS AND FUTURE HIV/AIDS INTERVENTIONS

7.1 IMPLICATIONS

This Study forms an important part of a largely under-researched area that is gradually gaining interest of researchers globally. While other types of FBO's in general have been part of a growing body of literature for the last half of the three decades of fighting HIV, a specific focus on church congregations, in particular, has been lacking.

The qualitative findings here-in underscore the significance of church congregations and the unique opportunity they offer as communities for immense social research owing to the rich and diverse demographic microcosm of society they cater for and represent.

7.1.1 The Role (s) of The Church and Theology: The Way Forward

Within its wide Mission[1] mandate to propagate the gospel of the Lord Jesus Christ, the Church cannot afford to be confused about its role and boundaries in dealing with the effects of HIV/AIDS on the community. In that sense, the church needs to take a leading role in preserving life, providing preventive direction and indeed providing care, comfort and love to the suffering. This means people of theological conviction

[1] In Evangelical Christian circles generally and Pentecostal or charismatic contexts in particular, Christian "Mission" involves the propagation of the Christian message of the love of Christ for mankind, invariably carrying the connotation that God is present and indeed concerned about human suffering and that He responds to humanity through answer to prayer and the loving actions of those who consider themselves messengers of the Christian gospel message.

going beyond the boundaries of the church to challenge legislation, traditions and pervasive tendencies that fuel the spread of the disease, contradict authentic Christian values or disadvantage those that have to live with the said challenges.

Paula Clifford, in her study on *Theology and the HIV/AIDS Epidemic,* encapsulated the reality of the church's journey with HIV/AIDS over the past few decades, when she stated that:

> HIV/AIDS poses a particular challenge for theologians. In the 1980s, some churches responded to HIV with the message that it was a punishment from God for what they understood to be immoral behaviour. This response caused untold harm. People who found themselves infected kept their positive status hidden in order to avoid stigma and rejection by their church and family. As the causes behind the spread of HIV, and its links to poverty and injustice, became better understood and with the realisation that HIV can infect anyone, regardless of their faith, marital status, sexual orientation or social position, churches had to recognize that HIV was in their midst. This meant acknowledging that the role of the church was not to condemn, but rather to offer comfort and support after the example of the God of hope and love, and to put that recognition into practice.[2]

As noted earlier, the Church in Zambia has long broken the silence regarding HIV and has made significant strides towards engagement in the fight against HIV. We restate Banda's (2011) summary of the church's history of engagement in the Zambian health sector as follows:

- The 'Early days' of HIV/AIDS in Zambia (1984 -1990) when the church response was somewhat sporadic and incidental and largely confined through its health and educational institutions
- The awakening of a 'Latent Conscience' (1991-2000) when awareness begun to grow towards increasing calls for greater involvement of faith-based institutions in specific HIV/ADS interventions

[2] Clifford, Paula. *Theology and the HIV/AIDS Epidemic, 2004-* www.christainaid.org Accessed 11th May, 2011

- The Constructive Engagement of Church congregations (2001- Present)[3]

Today, significant HIV responses are being implemented by and through Faith-based organisations like the Churches Health Association of Zambia (CHAZ), The Expanded Church Response (ECR) to HIV/AIDS Trust, with some massive collaborative and donor funded efforts via Consortia like the once World Vision Zambia-led RAPIDS.[4] Monumental responses in this respect have also been registered by congregations like the Go Centre's Chreso Ministries as well as our own congregation, Northmead Assembly of God Church, both of which congregations were the first to operate fully fledged, stand-alone clinics offering free anti-retroviral drugs to thousands of patients along with VCT services.

Admittedly, there is still a lot to be done. The role of the Church is constructively to show care, fight HIV related stigma while radiating the love of Christ. In specific regard to ethno-cultural matters, some of which are cited above, apart from being medically unsafe and posing a danger of fuelling HIV infection, these practices are in essence contradictory to God's set order for chastity and moral purity. Therefore, they should be handled correctively through the instructions of the Bible.

It goes without saying that the comparative advantage of the church in executing the God-given role could be described in a seven-fold fashion as follows:

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[3] Banda, Joshua H.K. (*MCP- The Experience of the Church in MCP: The Evangelical perspective)* in *"Multiple and Concurrent Sexual Partnerships"- A Consultation with Senior Religious Leaders from East and southern Africa.* Pan African Christian AIDS Network (PACANet), Jane Wambui Rosenow, ed., 2011, pg. 71

[4] RAPIDS = Reaching HIV/AIDS Affected People with Integrated Development and Support. The programmes under this Consortium were funded for 5 years by the United States government through USAID

- We promote Godly values, his love, grace, justice and forgiveness (John 3:16)
- We change beliefs, attitudes, actions and perceptions using the Bible (James 1:27)
- We change beliefs, attitudes, actions and perceptions using the Bible (2 Cor. 5:17)
- We promote build, nurture, mentor and support families-children, marriages (Titus 2:11-13)
- We promote Justice and human equalities (Micah 6:8)
- We address matters of human mortality and eternal destiny enabling the terminally ill to face impending death with hope (1 Thessalonians 4:13-17)
- We have presence (widely spread in numerous communities), longevity (in the community for the long haul) and harness massive human resources (including skills and stories) of those in God's spiritual family.

As for the role of Theology in the face of HIV in general, there is need to explicate what we understand to be practical Theology, as it is the facet that covers the kind of praxis under consideration. While "theology" *per se* is practiced and propagated in the churches, especially through pulpit ministry, most of the formal theologizing is carried out in our theological schools and /or Bibles colleges.

Having served as an Academic Dean (1989- 1990) and later the Principal (1990-1995) of a theological school, I confess that none of our courses at the time ever addressed HIV, although we offered some courses in cultural anthropology. Therefore, theological schools today need to affirm from the outset, the need to be

deliberate in designing courses that tackle directly and explicate sensitive issues that border on ethno-cultural factors related to the spread or control of HIV. This should arise from the premise that we are part and parcel of the problems facing society and so must be part of seeking solutions. We cannot afford to be indifferent to the challenges posed by the named negative cultural practices especially.

Swinton and Mowat (2006) defined Practical Theology as being characteristically a process of "critical, theological, reflection on practices of the Church as they interact with the practices of the world, with a view to ensuring and enabling faithful participation in God's redemptive practices in, to and for the world."[5] Swinton and Mowat argued further that Practical Theology is the realm encompassing the church's engagement in HIV responses:

> Takes human experience seriously; that it is a 'Place' where the Gospel is grounded, embodied, interpreted and lived out. An interpretative context, which raises new questions, offers new challenges & demands answers of the Gospel, which are not obvious when it is reflected on in abstraction. Acknowledges & seeks to explore the implications of the proposition that faith is a performative & embodied act; that the Gospel is not simply something to be believed, but also something to be lived. Takes seriously the actions of God in the present & as such offers a necessary contextual voice to the process of theology & theological dev. Human experience is an important locus for the work of the Spirit (1 Cor. 6:19).

7.1.2 The Way Forward

The church must engage society with what the researcher is here calling, a fresh Theology of Engagement. Markham (2003) talked about the need for a theology of engagement in the context of the divide between conservatives and liberals in America. He called for the need to narrow the divide and engage, one side the other. Often, there is somewhat of divide between church leaders (let us say, the Pulpit), congregants (let us say, the Pew) and the Community. Emerging from this research is

[5] J. Swinton & H. Mowat. Practical Theology and Qualitative Research, SCM, 2006

the fact that when the 'Pulpit' engages the 'Pew', they both will engage the Community more effectively. This theology of engagement grants the church more relevance to the society and HIV is just one of the entry points into society.

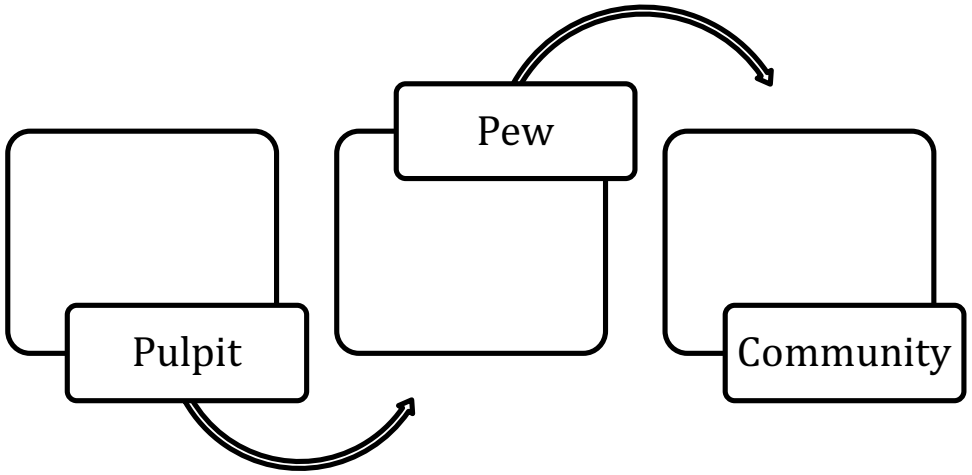

Figure 33: A fresh theology of of engagement

The Church needs to continue to progress with and, to some extent, beyond Caring and Loving. The Church can surely use its comparative advantage to address the important issues covered in this Thesis and more. Varied topical issues such as impacts of gender inequality must consistently be on the radar of consideration. The Church must continue to recognize and re-position Theology as a "rich and diverse discipline," whose range of approaches embrace "research which is empirical,

political, ethical, psychological, sociological, gender oriented, pastoral and narrative–based".[6]

Kunst (1992) wrote that "the Church does not exist fundamentally to meet needs; in its being, the Church, like Christ, exists to GLORIFY THE FATHER."[7]

Paula Clifford provocatively affirmed the role of the church as articulated thus far:

> The Church is called not only to act but also to act boldly. HIV/AIDS exists in the world, and we do not have the luxury of not engaging with that world. HIV needs to inform our theological thinking, which in turn must lead to appropriate action, whatever demands that might place on the internal workings of the church.[8]

Indeed, let the Church, through its millions of congregations, carry this task humbly and circumspectly. Let there be continuing commitment to spread the light of the transformative good news of the Gospel, bearing witness to God's eternal love and being fully determined to reverse the tide of HIV.

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[6] Ibid

[7] Kunst, JL. (1992) Towards a psychologically liberating pastoral theology, P.163

[8] Clifford, Paula. *Theology and the HIV/AIDS Epidemic, 2004-* www.christainaid.org Accessed 11th May, 2011

CHAPTER 8: IMPLICATIONS FOR POLICY AND LIMITATIONS AND RECOMMENDATIONS FOR FUTURE RESEARCH

8.1 IMPLICATIONS FOR THE NATIONAL RESPONSE

At the time of completing the last 3 chapters, the 2013-14 Zambia Demographic and health Survey (ZDHS) had been released. This latest population-based report observed, "*Young adults are more likely than their older counterparts to be in the process of establishing patterns of sexual behaviours and hence are the primary target of many prevention strategies*."[146] The ZDHS chapter presenting this result explains that the 2013-2014 survey set out "to examine levels of HIV and AIDS related knowledge and perceptions and the prevalence of risk behaviours related to HIV infection at the national, provincial, and rural" level. Further, it indicates the ultimate intention and purpose for this information is for eventual "prevention and control programmes [to] target those individuals most in need of information and most at risk of HIV infection."[147] However, the ZDHS (2013-14) has established that knowledge and awareness about HIV is "universal at this time, in Zambia [and] general awareness of AIDS among women and men is universal (99 percent and 100 percent, respectively), with no major variations by background characteristics."[148]

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[146] Zambia Demographic and Health Survey Report 2013-2014, pp99

[147] Ibid

[148] Ibid

With this level of awareness, there may be a lurking danger of complacency on one hand and a probable aggravation by 'inaction'' (Patterson, 2011) on the other hand. If the ultimate strategic goal of the national HIV response is to get zero new infections, zero stigma and discrimination, zero AIDS deaths (NASF 2006-2011, NAC reports 2008, 2010), then even a reduced national prevalence and possibly incidence rate leaves the nation yet far from reaching its golden target.

In the Household Population by Age and Sex section of the latest population survey under current reference, a pyramid feature of the population is presented, illustrating that the broad base of the pyramid as representing the fact that Zambia's population is young and that such a scenario is common in all countries with high fertility rates. It is also indicated on the basis of the pyramid picture, that there are slightly more females than males, especially under the age of 15.

This kind of finding is once again to seen as instructive. Zambia's focus must now turn towards scaling up high impact interventions among young people. It is well established that that HIV among adults is mainly transmitted through heterosexual contact between an HIV-positive partner and an HIV-negative partner (MOT Report 2009). Zambia's HIV prevention programme has sought vigorously to reduce sexual transmission of the virus by promoting three behaviour change strategies focusing on sexual abstinence, mutually faithful monogamy among uninfected couples, and consistent condom use among people not practicing abstinence (ZDHS 2013-14. It is therefore reasonable to insist that practical scale up in these key interventions will ensure the attainment of the triple target of Zero stigma and discrimination, Zero new infections, and Zero AIDS deaths.

8.2 IMPLICATIONS FOR GLOBAL, NATIONAL AND CHURCH POLICY

8.2.1 Nomenclatures (Key Populations: A Case of Zambia)

Learning from the Uganda case, where the rapid decline of HIV was suddenly met with charged debates regarding what really caused the decline, some attributed the trend reportedly to condom use and deaths (Gary *et al.* 2006; Wilson 2006) while others pointed to abstinence (A) and particularly faithfulness (B) yet not excluding condoms (Green, 2006;Kiirya, 1999; Green *et al. 2008;* Eipsten, 2007). Unfortunately, whilst the debate raged on, incidence and prevalence begun to rise again. So the matter is self evident: focus must be maintained on high impact interventions which are evidence informed.

Policy makers have the task to do in reality what is claimed on a myriad of well-written policy documents that may at times be remain unexecuted and the epidemic could resurge. The issue in Uganda's case was not that the debate should not have gone on. It is that precious time and focus for a given period wavered and gave way to polemics.

In Zambia's case, the lesson from Uganda would be (proverbially) to 'keep our eyes on the ball.' A policy level discussion that nearly shifted Zambia's attention was in regard to the classification of Key populations. Key populations are defined in UNAIDS terminology guidelines as:

> populations at higher risk of HIV exposure' refers to those most likely to be exposed to HIV or to transmit it – their engagement is critical to a successful HIV response i.e. they are key to the epidemic and key to the response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender persons, people who inject drugs, sex workers and their clients, and sero-

> negative partners in sero-discordant couples are at higher risk of HIV exposure to HIV than other people.[149]

As pre-empted in Chapter 1 of this study, the definition in itself as a pointer, is very important. However, on the ground, some funders often appear to narrow it down to men who have sex with men, sex workers and their clients, transgender persons and people who inject drugs. In most parts of Africa, this approach stirs up much controversy when it comes to funding proposals for the national response and what the programmatic priorities should look like.

It ought to be stated clearly that HIV response simply cannot be reduced to nomenclatures and terminologies. Defined terms like *key populations* ought to be understood directly in the context of what is detailed and dictated by the nature and progression of the epidemic. The question to be asked in the case of key populations is, who or what is the particular population that is key to a given epidemic? Nationals of many affected countries would prefer more holistic attention given in reality by donor governments and other international entities to nationally prioritised aspects of the response. As these international Actors work to reverse the devastating impact of the HIV pandemic, it is the contextual peculiarities that require prioritisation rather than controverted and sometimes merely polemical matters.

In 2013-14, Zambia was in the midst of a national exercise led by the National AIDS Council (NAC) to revise its National AIDS Strategic Framework. NAC seized the opportunity also to draw up a funding proposal to the Global Fund under a new funding model dubbed the 'Investment case.' Zambia rightly, elected to

[149] UNAIDS Guidance on terminologies (See Appendix).

optimise the opportunity in order to re-identify interventions with potential for highest impact in the HIV response.

A review of any document requires consultations at various levels, including sub-national structures in the urban and rural areas. For a process of this nature, the consultations involve engagement with international cooperating partners and donor representatives, civil society and churches.

It emerged, in due course that the matter of "key populations" was featuring regularly in the many of the stake holder discussions related to the said NASF review process. In the majority of cases, representatives of international funding agencies would raise the matter. In one instance, a named representative stormed out of a meeting in protest, as Zambia was now seeking to redefine its own understanding of key populations, which appeared to be in slight variance with the conventional definition.

With the protest walk out, came some verbal cautioning that Zambia risked losing the bid to have additional funding from the Global Fund, particularly if (in the view of the said official) it did not 'address key populations.' However, that is precisely what often begs the question. How does an attempt by a national task team to seek re-alignment of its HIV response based on its known local epidemiology, receive such a charged reaction from an international policy maker?

Being that it was an important policy matter, the author, then chairperson of the National AIDS Council, undertook a frank discussion with the NAC Board that eventually resulted in redefinition of 'key populations,' tailored to Zambia's context of the epidemic as a result, the relevant section of the R-NASF (2014-16) now reads as follows:

> Zambia has prioritised implementation of High Impact Interventions focusing on reaching key populations as part of its strategy to reduce new infections and improve life expectancy of PLHIV. The country, through NAC Council in 2014, has defined key populations as: People living with HIV; Women and children; Adolescents (10-14); Young people (15-24); People with disabilities; Prisoners; Sex workers and their clients; and Migrant and mobile populations. The expanded list is a deliberate attempt by Zambia to ensure that populations with historical and disproportionate lack of service access are identified and considered for programming. [150]

In the context of this research, the counsel to policy makers is to stay true to policies that are evidence informed. The full range of high impact interventions yielding notable results must continue to be prioritised. A multi-sectorial response must, in reality, take into account all players on the ground and Zambia has a wealth of well organised and energised civil society players as well churches. The chart below shows Zambia is on track.

C**hart 1.0**

How Zambia's prioritisation of key populations is addressed in the R-NASF:

Option B+:
1. These individuals are identified at all antenatal clinics where HTC is conducted during the booking visit (first visit). In facilities where ART is provided, these identified individuals will receive ART; otherwise they will be referred to the nearest ART-providing facility (pre-existing ART facility or PMTCT facility that have been mandated to provide ART). The individuals will receive support from networks of people living with HIV and AIDS, community health workers and Safe Motherhood Action Groups (SMAGs);

Discordance:
Couples counselling and testing is the mainstay strategy of Zambia's HTC guidelines and through this approach discordancy is identified at all HIV testing facilities and the HIV-positive partner is linked to care and the provision of ART under the 2013 guidelines;

Children (0-14):
The 2013 guidelines provide for all HIV-positive children to receive ART regardless of CD4 count; and,

All members of key populations who qualify for ART provision receive access to ART irrespective of their status or inclination

[150] R-NASF 2014-16

8.2.2 Conditional Funding and a Narrowed Human Rights Approach

We turn to a matter that is admittedly thorny and has not been absent from various considerations and treatment in academic journals and theses (Klinken, Adrian s. 2011[1]). It may be useful to discuss it in view of what was raised in the prolegomena chapter and the strongly behaviourally based findings of this research,.

Zambia, like a number of other African countries, has laws criminalising homosexuality and related acts deemed unnatural. In the current Zambian Constitution (in the Penal Code Chapter 87 of the laws of Zambia), Section 155 says: "any person who has carnal knowledge of any person against the order of nature or (c) permits a male person to have carnal knowledge of him or her against the order of nature; commits a felony and is liable, upon conviction, to imprisonment for a term of not less than 15 years and may be liable to imprisonment for life." Now this may appear purely punitive and one can not be faulted necessarily for holding such a view.

However, various players in the global community are pressurising for a wholesale decriminalisation of homosexuality, which moves are opposed strongly by the majority of African States.

One of the most defining public pronouncements made in recent times that illustrates how high on the global priority list the LGBT agenda has ascended, is the high level statement made by Prime Minister Cameron at the 2011 Commonwealth

[1] KIinken, AS, The homosexual as an antithesis of biblical manhood? Heteronormativity and masculinity politics in Pentecostal sermons in Zambia, Journal of gender and Religion in Africa., Vol. #2 (December 2011)

gathering in Australia, where he threatened that "…countries that ban homosexuality [risk] losing aid payments unless they reform."[2]

The Guardian Newspaper reported, however, that Mr. Cameron was quick to concede that "

> Deep prejudices "in some countries meant the problem would persist for years. Mr. Cameron stated plainly that Britain was "putting the pressure on", though "it was not a problem that would be solved by the time Commonwealth leaders are next due to meet, in Sri Lanka in 2013," while warning Sri Lanka "to improve its human rights record or face boycotts of the 2013 Summit."[3]

Further, the Guardian carried the following continuation of remarks by Mr. Cameron at the 2011 Australia Commonwealth meeting of Heads of Government:

> Ending bans on homosexuality was one of the recommendations of a highly critical internal report on the future relevance of the Commonwealth, written by experts from across the member nations. "We are not just talking about it. We are also saying that British aid should have more strings attached," Cameron said on BBC1's Andrew Marr Show in an interview recorded at the summit in Perth. "This is an issue where we are pushing for movement, we are prepared to put some money behind what we believe. But I'm afraid that you can't expect countries to change overnight.[4]

A similar call was made by the then USA Secretary of State, Hilary Clinton, and which story anchored as follows on the BBC:

> The US has publicly declared it will fight discrimination against gays and lesbians abroad by using foreign aid and diplomacy to encourage reform. Secretary of State Hillary Clinton told an audience of diplomats in Geneva: "Gay rights are human rights". A memo from the Obama administration directs US government agencies to consider gay rights when making aid and asylum decisions.[5]

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[2] http://www.guardian.co.uk/politics/2011/oct/30/ban-homosexuality-lose-aid-cameron?newsfeed=true Accessed November 2011

[3] Ibid

[4] Ibid

[5] **http://www.bbc.co.uk/news/world-us-canada-16062937** Accessed November 2011

8.2.3 A Matter of Dignity and Justice

It will be noted that the above approach is reminiscent of a prejudicial construct that essentially minimises the worth of the African peoples, as they are often stereotyped, chiefly by western media and portrayed wrongly as being out-dated in their attitudes to same sex behaviour and lifestyle. It amounts to a redefinition of 'human rights', which are now re-prescribed conditionally for donor-aided nations.

This is a violation of the dignity of the African people and a total disregard of their worth. The normal course of justice demands a fairer way in which the people are respected for who they are and therefore allowed to determine their own position on such matters.

8.2.4 A Possible Clash of Viewpoints on Human Autonomy

It may well be contended here that what is at play in the whole scenario is a 'clash' of viewpoints regarding human autonomy as understood by those in the North and those in the South. For instance, the Western concept of human rights and tolerance is deeply located in an individualistic understanding of human autonomy, which is grossly at variance with the African value of common good that is deeply rooted in culture.

In this respect, some pertinent questions raised by Chris Sugden in a similar context must be asked, one of which is "whether human rights are universal and are to be imposed *sui generis* in different cultures."[6] Another line of inquiry for further reflection is:

[6] Sugden, Christopher. Concept note: *Human rights and Sexuality* Consultation [unpublished]

> How is the question of cultural defence of human rights to be addressed in the face of such unguarded universal claims by donor countries? Is "inclusion" to be understood as inclusion of limitless individual preferences or is it to be related to "the common good?" Where is the balance to be found between individual agency and common good?[7]"

8.2.5 What Could be the Reality behind Redefinition of Human Rights?

The seeming redefinition or in the least, the narrowing of human rights in this fashion is unproductive and untenable. A brief look at the subject of human rights may be necessary.

In a Paper presented in Stellenbosch (2010), I mention Human Rights as generally understood to refer to the rights and freedoms to which all human beings are entitled.[8] The most comprehensive compilation of fundamental human rights is the United Nations' Universal Declaration of Human Rights (UDHR) having developed in the aftermath of the Second World War, in part as a response to the Holocaust, and culminating in its adoption by the United Nations General Assembly in 1948.[9] In modern society, it is widely held that basic human rights include civil and political rights as well as economic, social and cultural rights.

Owing to the limited scope of the current discourse, we will not delve further into the various theoretical distinctions that exist in regard to these rights. Suffice it to say that the division of human rights into three generations[10] was initially proposed in 1979 by the Czech Jurist Karel Vasak at the International Institute of Human Rights in Strasbourg. It is said that he used the term at least as early as

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[7] Ibid

[8] Karel Vasak, "*Human Rights: A Thirty-Year Struggle*: the Sustained Efforts to give Force of law to the Universal Declaration of Human Rights", *UNESCO Courier* 30:11, Paris: United Nations Educational, Scientific, and Cultural Organization, November 1977.

[9] Karel Vasak

[10] His divisions follow the three watchwords of the French Revolution: Liberty, Equality, Fraternity. The three generations are reflected in some of the rubrics of the Charter of Fundamental Rights of the European Union. The Universal Declaration of Human Rights includes rights that are thought of as second generation as well as first generation ones, but it does not make the distinction in itself (the rights listed in it are not in specific order).

November 1977. Vasak's theories have essentially taken root in European law, as they primarily reflect European values.[11]

In the context of Africa, one needs to familiarize with the African Charter on Human and Peoples' Rights (also known as the Banjul Charter) which is an international human rights instrument that is intended to promote and protect human rights and basic freedoms in the African continent.[12] The African Commission on Human and Peoples' Rights (ACHPR) is a quasi-judicial body given the task to promote and protect human rights and collective (peoples') rights throughout the African continent as well as to interpret the African Charter on Human and Peoples' Rights and consider individual complaints of violations of the Charter.

Ruark and Green (2011) caution that:

> "We should not need the impetus of AIDS to make protecting human rights a matter of prime importance and urgency. The danger is that the cause of human rights may be used to justify investing significant resources in programs that have little or no prevention impact on HIV infections."[13]

It is desirable that Africa prioritises what is most important to her, without outside interference. This will give her a chance to construct her own relevant approaches towards matters of sexuality informed by her own felt needs and priority areas.

[11] D. Kaufmann • Chapter in Human Rights and Development: Towards Mutual Reinforcement • Edited by Philip Alston and Mary Robinson. Human Rights and Governance: The Empirical Challenge

[12] Karel Vasak

[13] Green Edward, C and Ruark A. H. 2011. AIDS, Behavior, and Culture: Understanding Evidence-Based Prevention, New York: Left Cost Press, Inc.

8.2.6 Further Implications for the Church

A question may be asked. What could church congregations do about this global campaign while staying focused on a holistic transformation of society? What are the eventual implications towards our basic understanding of human sexuality in general?

The Church must determine to hear God afresh concerning Africa while taking steps carefully to clarify its belief base and increase on its witness.

The Church must assist Africa to set its own agenda in regard to the discourse on sexuality and the interplay with HIV/AIDS.

The Church must employ contextualised reflection on its praxis through rigorous evidence-informed research in the face of the AIDS pandemic.

Equally important is the need to develop balanced sexual reproductive health messages from a faith perspective.

Further, there is need for better documentation of stories of people in the communities' best practices. Such voices generate data for research.

In the quest towards holistic transformation, the Church must be more deliberate in its witness to the Marginalised and Most-At-Risk Populations (sex workers, etc.) including LGBT persons. The church has to be self-critical as well to avoid stereo typing persons.

8.2.7 A Call for Action for Global, National and Religious Leaders

In the light of a fairly controverted HIV environment in many respects, whether it be controversy over human rights aspects of the HIV response or the age old ABC debate, all who wish to participate meaningfully towards reversing the trends of new

infections and to bring the HIV epidemic under control will be required to take more sober approaches and create dialogue links with all involved, even if they differ in respective positions or perspectives held dear. The epidemiology of the disease is what must instruct all. So what do we know?

We know that incidence is dropping quite rapidly in some parts of the nations affected and that essentially, if for arguments sake, HIV prevalence as well is averaging 7% in the Sub-Saharan region (Green 2004) then we must agree with Green (2004), that it means approximately 93% of the persons in these regions are HIV negative. There is need for a paradigm shift (Green and Ruark, 2006) in order for actions to refocus on "prevention and behavioural AB efforts", suggests Green (2004), and there is need to note evidence of studies showing that "the trend in Africa is towards higher levels of monogamy and fidelity and it is [likely] that HIV [infections] trend will eventually be down ward" (Green 2004). This is a call for all to hold hands and raise one banner- an HIV free global village at all costs!

8.2.8 Limitations of the study and Recommendations for Future Research

One limitation of this study is that it was located in the city of Lusaka only due to funding. It would be desirable to extend a study of this nature to other provinces.

A second limitation is that the study sample, though yielding significant results, was comparatively small, coupled with the choice of the convenience sampling method. Although all the necessary safeguards were undertaken to ensure credibility and reliability of the data from the point of selection of the target population to the collection of data, a randomised study with a much larger sample would be a further test for the operational hypothesis which has been proved by the

study. Admittedly, these findings are applicable primarily contextually and cannot be applied in a blanket manner to the larger universe.

A third limitation, particularly reminiscent of reflections from open ended qualitative interviews, is the tendency for the responder to more or less gravitate towards often telling the interviewer what they want to hear.

A possible area of future research is to explore whether the findings of this study are peculiar to Pentecostals as a result of the Pentecostal message or they could be generalised to the rest of the Christian churches. What would the picture look like if it were implemented for instance, in a Catholic congregation? And what would a similar study among people of other faiths like Muslims, look like?

CHAPTER 9: SUMMARY AND CONCLUSIONS

This thesis has presented a study, which set out to investigate how interventions affect impacts in congregation-based HIV/AIDS programmes, and how abstinence and marital fidelity function within the larger picture of overall strategies to combat AIDS. The study located its inquiry around the community outreach work of the Circle of Hope Family Care Centre, a congregation-based HIV/AIDS support group initiative undertaken by the Northmead Assembly of God Church in Lusaka, Zambia

The Thesis begun with an introduction and over view of the problem addressed. Indicated how Zambia's HIV prevalence rate, in the early days of the epidemic was as high 20 % in has seen a steady decline over the years to an estimated at 13.3% in 2015. The Thesis showed how governments and international organisations responded, as well as how Churches have been seen as holding massive comparative advantage towards facilitating sustainable interventions for prevention and mitigation of the AIDS impact. However, church-congregation engagement in AIDS work has remained under-researched and their interventions often undocumented and unmeasured in relation to impact; in addition they remain inadequately funded.

The thesis proceeded to narrate the background and precursory circumstances including life interactions that drew the researcher's interest to the study here presented. Relevant literature to the subject of inquiry was explored and the rationale, approach and detailed design and methodology chosen for the research were presented.

As abstracted earlier, a triangulated methodology required the collection of both quantitative and qualitative data. The experimental design included a purposively selected intervention group and a control group. Both groups were studied by employing a baseline first, and follow-up measures after three months.

The working hypothesis was that a person's ***sexual behaviour is influenced by their attitude and behaviour towards God and was tested through a congregation-based intervention centred on Life Transformation Seminars offering biblical content complemented by Focus group discussions.*** These measures provided an opportunity for in-depth interviews and the collection of qualitative data.

Quantitative data analysis was carried out in two stages comprising first, *cross tabulations* to examine the relationship between safer sexual behaviour and socio-economic variables. Logistical regression models were carried out establishing various determinants of sexual practices including abstinence and marital fidelity.

The key finding of the study following the logistic regression analysis showed that those who participated in the interventions were *4.1 times* more likely to report having adopted new behaviour or modified old behaviour, specifically to live positively, than those who did not attend the interventions.

Similarly, participants in the faith-based interventions were *2.3 times* more likely than those who did not take part to report having adopted safer sexual practices. Further analysis revealed that those participants were more likely to report abstinence from sex than those who did not attend.

The conclusion is that church congregations have immense comparative advantage through presence in the community. Additionally, their morally based interventions such as abstinence and marital fidelity show significant impact and

have potential to turn the tide of HIV/AIDS as the models herein are replicable, scalable and sustainable. The intervention was therefore observed as having been significantly effective in altering the sexual behaviour of its participants.

The Thesis then proceeded to discuss thematic issues emerging from the data findings, chiefly, the importance of the statistical and practical significance of the impact of the intervention at the centre of this study and the important call to refocus on sexual behaviour change as an assuring approach of church congregations, given their moral and spiritual advantage. The Thesis specifically proposed how abstinence and marital fidelity do function in church congregations and how they could function better.

Also discussed as emergent from the data are topical leanings towards a largely so called human rights–driven, western approach to the HIV epidemic and that this approach (without prejudice, represents sexual minority rights). Though understandable given the numerous human rights violations globally, the approach now risks a shift of emphasis from other critical issues that are epidemiologically, socially rooted in many non-western contexts.

The thesis notes that the nationals of many affected countries would prefer donor governments and other international entities working to reverse the devastating impact of the HIV pandemic, to give more attention to contextual peculiarities and required prioritisation rather than focusing on controverted and sometimes merely polemical matters. Of particular concern, even after three decades of global responses to HIV, is the attachment of conditionality to AIDS-related Aid which might appear to have underlying indications that may indirectly induce a focus away from national priorities.

Therefore, based on the finding of this study, the discussion sections called for a fresh attention to behavioural interventions and to partnerships with churches and other FBOs.

Further, in drawing implications from the data, having established the effectiveness of a biblically based intervention in changing sexual behaviour, the Thesis calls the Church to engage with society, understanding that it has a mission to deliver hope to society, which in the words of Jesus Christ, has people who are "bruised[1]" by disease and divers calamities and need "comfort," care and healing.

However, the Church must use its comparative advantage to address other important issues covered in the Thesis, recognising and re-positioning itself as relevantly as possible with what Kurnst termed, a Theology that has a "rich and diverse discipline," whose range of approaches embraces "research which is empirical, political, ethical, psychological, sociological, gender oriented, pastoral and narrative–based".[2] The Thesis has proceeded to propose a Theology of Engagement. In the latter part, the Thesis has made recommendations for policy action, drawn attention to some limitations of the Study and has recommended two areas for possible future research to build on its findings.

9.1 Conclusion

This research has opened a window of firm ground regarding interventions that target sexual behaviour: that they do work and that change happens within in Church congregation settings as shown in the study. Therefore, these interventions,

[1] Luke 4:18 and Matthew 9:36

[2] Ibid

particularly for congregations, do not need to be resource-intensive, as they can be carried out within existent means and also that the impact of such interventions can inform further actions and policies to reverse the tide of HIV. Congregation-based interventions have potential to alter sexual behaviour and therefore remain key to an impactful future of HIV response.

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APPENDICES

Appendix 1 - Impact Of Congregation-Based HIV/AIDS Programmes In Lusaka, Zamba: How Abstinence And Marital Fidelity Efforts Function In Overall Strategies Addressing HIV/AIDS (Information Sheet)

INFORMATION SHEET

Good day, my name is _____ (insert name). I am from the Circle of Hope (COH) Family Care Centre. We are carrying out a study to evaluate HIV/AIDS programmes in churches. We are looking into creating awareness about the transmission of the AIDS virus and the methods of risk reduction through preventive measures such as abstinence and marital faithfulness

You are invited to participate in the study. If you agree to participate, you will sign a form. This is just to register your willingness. After that you will be required to answer some questions and interviews which will not take more than 20-25 minutes of your time

Withdrawal without Prejudice: Your participation is voluntary. You are free to withdraw from the study at any time without prejudice or penalty

Potential Risks/Discomforts: Your participation will not cause you any physical risk of harm. However, some questions might be sensitive. Feel free to refuse to answer such questions if you become uncomfortable at any point

Potential Benefits: There is no direct personal benefit, payment or compensation for your participation in the study. However, the information gained in this study will help our society to understand better the impact and effectiveness of HIV/AIDS programs implemented through congregations. It will also assist the programme managers to plan better for future HIV programs in Zambia.

Cost of Participation: There will be no costs to you for taking part in this study.

Confidentiality: All information collected during interviews and through questionnaires is confidential and will therefore be kept with utmost privacy. Information can only be released if requested for. All attempts will be made to ensure that there is no leakage of any information between participants or with the interviewer. **Your name will not be written** on the study forms, and will never at any time be used in connection with any of the information you give.

Questions: If you have questions or concerns after the interview, you may contact the Principal Investigator at Northmead Assembly of God Church, Plot 2131 Paseli Road, Box 31598, Lusaka, (Telephone: 0977774763; email: jhkbanda@zamnet.zm) or the Chairperson, Biomedical Research Ethics Committee of the University of Zambia, Ridge way Campus, Box 50110, Lusaka, (Telephone: +260-211-256067; email: unzarec@unza.zm).

Appendix 2 - Chinyaja (Local Language) Version (Information Sheet)

ZICITIDWE ZAMUMPINGO-PANDONDOMEK YA KADOYO KALIWONDE-WONDE MUDELA YA LUSAKA-ZAMBIA. MWAMENE KUZILESA KUKHULUPILIKA MU CHIKWATI KUTHANDIZA MUNJILA ZONSE ZONKHUZA KADOYO NDI MATENDA YA KALIWONDE-WONDE.

PEPELA YACIDZIWITSO

Tikuoneni, dzina langa ndi…….[lembani/ ikani dzina] ndichokela ku guru yaci yembekezo [COH] yosamalila ma banja. Tili kuchita maphuzilo kuona ndondomeko ya kadoyo/matende yakaliwonde-wonde mumipingo. Tili kusanda-sanda mwamene tinga dziwitsilane zaka yambulidwe ya kadoyo\ matenda yakaliwonde-wonde ndi ku chepetsa ciopsyezo kupyolera njira zo cinjiliza monga kudziletsa ndi kukhulupilika mu ukwati. **Tifunsa kulowa pa zocitika kulingana ndi njira zomwe mipingo zisebenzetsa kucipetsa kalombo ka HIV ndi matenda yakaliwonde-wonde.**

Mwaitanidwa kutengako mbali mu cimphunzitso ici. Ngati mubvomela kutengako mbali, muza saina pepala. Ici ndikufuna kuwonetsela kudzi peleka kwanu. Ngati mubvomeledza kutengako mbali muyembekezedwa kuyamba mafunso ndi kufotokodza chamene sichizakutengelani mphindi zosakwanila makhumi awiri kapena mukhumi awiri ndi zisanu ya nthawi yanu.

Kuleka ngati mufuna: kutengako mbali ni chifunilo chanu. Muli omasuka kuleka kuona pa nkhani iyi pa nthawi ili yonse kopanda chokumangani kapena ndapusa.

Chiwonpsyezo/zozinga: kutengako mbali kwanu sichizakutengani inu chiopsyezo kepena kupwetekedwa. Komatso mafunso ena yanga khale yodzidzitswa. Khalani womasuka kukana kuyankha mafunso yokukhuzani pa nthawi ili yonse.

Zophindula: kulibe zophindula zeni-zeni; koma malipilo kapena malipilo patengako mbali mu cimphunzisto chomwechi. Komatso cimphunzitso mwa mphunzila cizathandiza mu zinda wathu kumvetsa bwino zochitika ndi zokwanilitsika ndondomeko yakadoyo ndi matenda yakaliwonde-wonde zocitikila mumipingo. Cizanthandizanso woyanganila ndondomeko yakodoyo mu Zambia. Malipilo otengako mbali kuci mphunzitso ici citsinsi. Nkhani zonse zotengedwa ndi mafotokozedwe ndiza citsinsi, ndipo mwaici zizasamalika mobisika. Nkhani ingaulisidwe ngati kwa pemphedwa. Tizayetsetsa kuti pasa nkhale ku-ulula nkhani iyi pakati paotenga mbali ndi ofuntsa. Dzina lanu tsizalembedwa pama pepala ya nkhani ndiponso tsidzasebenzesedwa pa nthawi ili yonse kulingana ndi nkhani yomwe mwa patsa.

Mafunso: ngati muli ndimafunso kapena mandandaulo pakutha kukambilana mungaonane ndi akulu ofufudza ku Northmead Assemblies of God Church plot 2131 mumuseu wa paseli box 31598 Lusaka. [Lamya 0977774763, Email : jhkbanda@zamnet.zm.] kapena a chaimani Biomedical Research Ethics Committee of the university of Zambia, Ridgeway Campus Box 50110, Lusaka [Lamya; +260-2256067; email unzarec@unza.zm

Appendix 3 - Impact Of Congregation-Based HIV/AIDS Programmes In Lusaka, Zamba: How Abstinence And Marital Fidelity Efforts Function In Overall Strategies Addressing HIV/AIDS (Informed Consent Form)

INFORMED CONSENT FORM

Good day, my name is _____ (insert name). I am from the Circle of Hope (COH) Family Care Centre. We are carrying out a study to evaluate HIV/AIDS programmes in churches. We are looking into creating awareness about the transmission of the AIDS virus and the methods of risk reduction through preventive measures such as abstinence and marital faithfulness

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Potential Benefits: There is no direct personal benefit, payment or compensation for your participation in the study. However, the information gained in this study will help our society to understand better the impact and effectiveness of HIV/AIDS programs implemented through congregations. It will also assist the programme managers to plan better for future HIV programs in Zambia.

Cost of Participation: There will be no costs to you for taking part in this study.

Confidentiality: All information collected during interviews and through questionnaires is confidential and will therefore be kept with utmost privacy. Information can only be released if requested for. All attempts will be made to ensure that there is no leakage of any information between participants or with the interviewer. **Your name will not be written** on the study forms, and will never at any time be used in connection with any of the information you give.

Questions: If you have questions or concerns after the interview, you may contact the Principal Investigator at Northmead Assembly of God Church, Plot 2131 Paseli Road, Box 31598, Lusaka, (Telephone: 0977774763;email: jhkbanda@zamnet.zm) or the Chairperson, Biomedical Research Ethics Committee of the University of Zambia, Ridge way Campus, Box 50110, Lusaka, (Telephone: +260-211-256067; email: unzarec@unza.zm).

CONSENT AGREEMENT

The above document describing the benefits, risks and procedures to participate has been read and explained to me, the participant. I also understand that joining this study is voluntary and that I can withdraw at any time. I have been given an opportunity to ask any questions about the activity and be satisfactorily answered. I agree to participate as a volunteer.

_____ _____

Printed name of Participant Thumb Print

_____ ___

_____

Signature of Participant Date

CONFIRMATION OF CONSENT OBTAINED:

I certify that the nature, purpose, potential benefits and possible risks associated with participation in this exercise have been explained to the individual participant.

_____

Printed Name of Person Who Obtained Consent

_____ _____

Signature of Person Who Obtained Consent Date

Appendix 4 - Chinyaja (Local Language) Version- (Informed Consent Form)

ZICITIDWE ZAMUMPINGO-PANDONDOMEKO YA KADOYO KALIONDE-WONDE MUDELA YA LUSAKA-ZAMBIA. MWAMENE KUZILESA KUKHULUPILIKA MUCHIKWATI KUTHANDIZA MUNJILA ZONSE ZONKHUZA KADOYO NDI MATENDA YA KALIWONDE-WONDE.

CHIDZISTSO CHOBVOMEKEZEKA

Tikuoneni, dzina langa ndine ……..……..[lembani dzina]. Ine ndachokera ku guru yaci yembekezo [COH] yosamalila ma banja. Tisanda kuti tiwone ma ndondomeko ya kadoyo mwamene tingapangile kudziwitsana Zaka yambulidwe ya kadoyo ya matenda yakaliwonde- wonde ndi njira ya kuchipetsa chiwopsedwe ya mu njira ya kuchipepetsa kupyolera mu njira zoletsa monga kudziletsa ndi kukhulupilika.

Ngati mubvomeledza kutendengako mbali muyambe kuziwa kuyankha mafunso ndi kufotokoza chamene sichizakutengeleni mphindi zosakwanila makhumi awiri kapena makhumi awiri ndi zisanu ya nthawi yanu.

Kuleka ngati mufuna: kutengako mbali ni cifunilo chanu. Muli omasuka kuleka ku wonapo pa nkhani iyi pa nthawi iliyonse kopanda chokumangani kapena ndapusa.

Chiwopsyezo/Zozinga: kutengako mbali kwanu sichizakutengelani inu chiwopsyezo kapena kupwetekedwa. Komatso mafunso ena yanga nkhale yodzidzitswa. Nkhalani womasuka kukana kuyankha mafunso yokukhuzani pa nthawi ili yonse.

Zophindula: kulibe zophindula zeni-zeni koma malipilo kapena malipilo potengako mbali mu cimphunzitso mwa mphunzilo cizathandiza muzinda wathu kumvetsa bwino zochitika ndi zokwanilisika ndondomeko ya kadoyo ndi matenda yakaliwonde-wonde zochitikila mumimpingo. Cizathandizanso woyanganila ndondomeko kuika mumalo mwake ndondomeko ya kadoyo/ matenda ya kaliwonde-wonde mu Zambia.

Malipilo otengako mbali: sikuza nkhala kuli pila pontengako mbali kuchimphunzitso ici.

Citsinsi : nkhani zonse zotengedwa ndi mafotokozedwe ndiza citsinsi ndipo mwaici ngati zizasamalika mobisika. Nkhani inga ulisidwe ngati kwapephedwa. Tizayetsetsa kuti pasa nkhale ku-ulula nkhani iyi pakati pa otengako mbali ndi ofutsidwa. Zina lanu tsidzalembedwa pama pepala ya nkhani ndiponso tsidzalembesedwa pa nthawi ili yonse kulingana ndi nkhani yomwe mwe putsa.

Mafunso: ngati muli ndimafunso kapena madandaulo pakutha kukambilana munga onane ndi akulu ofufudza ku Northmead Assemblies of God Church plot 2131 mumuseu wa paseli box 31598 Lusaka. [Lamya 0977774763, Email: jhkbanda@zamnet.zm.] kapena a chaimani Biomedical Research Ethics Committee of the university of Zambia, Ridgeway Campus Box 50110, Lusaka [lamya; +260-211-256067; email unzarec@unza.zm

ZOBVOMELEZANA

Ili pepala yomwe ifotokoza mphoto chiopsyezo ndi njira yaku tengako mbali yabelengedwa ndikufotokozedwa kwa ine, otengako mbali ndiponso ndi mvetseksa kuti kugwapo paci mphunzitso ici chili kwa ine ndipo ndikhoza kuleka nthawi iyi yonse. Ndipatsidwa mupata kufinsa mafunso ali onse pazicitidwe ndipo ndakhutila ndi mayankho. Ndibvomela kutengako mbali monga ozipeleka.

_____ _____

Dzina la otengako mbali Kufwatika

---------- ----------

Sainecha ya otengako mbali Tsiku

CITSIMIKIZO COBVOMELEZEKA

Nditsimikiza kuti cikhalidwe, lingo, mpindu ndi zoipsyezo zokhudza ku otengako mbali muzo chitika izi za fotokozedwa ku ali yense otengako mbali.

_____

Dzina la munthu ololedwa

_____ ----------

Sainecha ya munthu ololedwa Tsiku

Appendix 5 - Impact Of Congregation Based HIV/AIDS Programmes In Lusaka-Zambia: How Abstinence And Marital Fidelity Efforts Function In Overall Strategies Addressing HIV/AIDS (Questionnaire)

QUESTIONNAIRE

(Estimated time - 15 to 20 minutes)

[Interviewer Note: Please record the response as obtained in the execution of the Consent Form. Did the individual agree to participate in the study?]

Yes [1] → (Continue with the interview)
No [2] → (Terminate the interview)

No.	QUESTIONS, INSTRUCTIONS & FILTERS	RESPONSES	GO TO
	SECTION – 1: BACKGROUND CHARACTERISTICS		
Q101	Sex of the Respondent (RECORD DO NOT ASK)	Male 1 Female 2	
Q102	In what month and year were you born? (ASK FOR THEIR NRC CARD IF THEY APPEAR UNSURE)	Month_____ Year_____	
Q103	How old were you at your last birthday? (COMPARE Q102 AND Q103, CORRECT IF INCONSISTENT)	Age in completed years_____	
Q105	How many years of schooling have you completed altogether, including primary, secondary and tertiary education?	Years completed_____	
Q107	Do you presently live: **READ OUT**	Alone 1 With family (relatives) 2 With Employer 3 With peers/friends/co-workers 4 Other (Specify)_____	
Q109	Do you or any members of your household own: (READ LIST, CIRCLE '0' IF ITEM NOT OWNED) (MULTIPLE RESPONSES POSSIBLE) (If items are not working ask whether it has ever worked during the past three months).	A Bicycle 0 1 A Motor-cycle 0 1 A Car 0 1 A Van or truck 0 1 A Video player 0 1 A Cassette Player 0 1 A Radio 0 1 A Television 0 1 A Refrigerator 0 1 A Farm 0 1 A House 0 1 A Cell phone 0 1	
Q110	Does your household have any of the following? READ LIST (If facilities are not working ask whether it has ever worked during the past three months).	A telephone (land line) 0 1 Electricity 0 1 Piped water into household 0 1 Flush latrine 0 1	

No.	QUESTIONS, INSTRUCTIONS & FILTERS	RESPONSES	GO TO
Q111	What is your functional status? **READ OUT**	Healthy, able to work/go to school 1 Sick, unable to work/go to school- 2 Bed ridden 3 Requires nursing 4 Other (Specify)_____	
Q112	What is your current working status? **READ OUT**	Currently working 1 Absent from work 2 Unemployed 3 Looking for work 4 Other (Specify)_____	
Q113	Which best describes your total personal income during the past year?	Amount _____	
Q114	In the last three months have you spent money on any of the following: **READ OUT**	Drinking in a bar 0 1 Dancing in a night club 0 1 Cigarettes 0 1 Other (Specify)_____	
	SECTION 2: MARRIAGE AND CHILD BEARING		
Q201	What is your current marital status? **READ OUT**	Single 1 Married 2 Divorced 3 Separated 4 Widowed 5	
Q202	Have you ever fathered / given birth to any children?	Yes 1 No 0	→ **Q301**
Q203	How many sons and daughters have you fathered/given birth to who are still alive?	No. of living sons_____ No. of living daughters_____	
	HEALTH CARE		
Q301	In the last 12 months, have you or any member of this household been denied care from a health facility because you could not pay?	Yes 1 No 0 Do not know/Not sure 8	
Q302	In the last 12 months, have you or any member of this household been prescribed medicine that you didn't obtain because you couldn't pay?	Yes 1 No 0 Do not know/Not sure 8	
Q303	Are there any members of this household who have gone to live elsewhere because you have been unable to cater for them during the last 12 months?	Yes 1 No 0 Do not know/Not sure 8	→ **Q305** → **Q305**
Q304	If yes, how many?	Number_____	
Q305	Are there any persons living or keeping in this household because their own households have been unable to cater for them during the last 12 months?	Yes 1 No 0 Do not know/Not sure 8	→ **Q307** → **Q307**

No.	QUESTIONS, INSTRUCTIONS & FILTERS	RESPONSES	GO TO
Q306	How many orphans under the age of 16 are living in this household?	Number _____	
Q307	Do you consider your household's living standards to have improved, remained the same or deteriorated during the last 12 months?	Improved 1 Remained the same 2 Deteriorated 3 Don't know 4	
	FAITH BASED INTERVENTIONS		
Q401	What is your religious denomination?	African Methodist 1 UCZ 2 7th Day Adventist 3 Reformed Church 4 Baptist 5 New apostolic 6 CMML 7 Salvation Army 8 Jehovah's Witness (Watchtower) 9 Pentecostal 10 Presbyterian 11 Anglican 12 Catholic 13 Muslim 14 Hindu 15 Other (Specify)_____ 99 None	
Q403	How long you have been attending the religious denominations?	Number_____	
Q404	Have you ever been born again?	Yes 1 No 0	
Q405	Have you been baptized?	Yes 1 No 0	
Q406	In the past three months, how often have you attended church services? **READ OUT**	Never 1 At least once 2 Two times 3 More than two times 4	
Q407	In the past three months, how often have you attended prayer meetings? **READ OUT**	Never 1 At least once 2 Two times 3 More than two times 4	
Q408	In the past three months, have you attended any counselling services?	Yes 1 No 0	→ **Q410**
Q409	In the past three months, how many times have you attended counselling services?	Number	
Q410	In the past three months, have you attended any healing seminar?	Yes 1 No 0	→ **Q412**
Q411	In the past three months, how many session have you attended?	Number_____	
Q412	In the last three months, have you attended any faith based workshop/discussion group?	Yes 1 No 0	→ **Q414**

No.	QUESTIONS, INSTRUCTIONS & FILTERS	RESPONSES	GO TO
Q413	In the last three months, how many sessions you have attended faith based workshop/discussion group?	Number_____	
Q414	Does your pastor advocate for the care of people who have HIV?	Yes 1 No 0	
Q415	In the last four weeks how often have you prayed to God? (READ OUT RESPONSES)	Every day 1 At least once a week 2 Less than once a week 3 Not at all 4	
Q416	In the last four weeks, how often have you read the Bible? (READ OUT RESPONSES)	Every day 1 At least once a week 2 Less than once a week 3 Not at all 4	
Q417	Have you attended any spiritual counseling session during the last three months?	Yes 1 No 0	
Q418	Have you participated in any prayer for healing during the last three months?	Yes 1 No 0	
Q419	Have you ever been hospitalized for any emotional problem?	Yes 1 No 0	→ **Q501**
Q420	Are you currently taking any medication for any emotional problems?	Yes 1 No 0	
	DRUG ABUSE SECTION		
Q501	Have you ever drunk alcohol?	Yes 1 No 0	→ **Q504**
Q502	What alcoholic drinks have you taken during the last three months? (MULTIPLE RESPONSES POSSIBLE)	Beer 0 1 Wine 0 1 Whisky/Brandy 0 1 Other specify_____	
Q503	During the last three months how often have you had drinks containing alcohol? Would you say .....**..READ OUT CIRCLE ONE**	Every day 1 At least once a week 2 Less than once a week or never 3 DON'T KNOW 4 NO RESPONSE 9	
Q504	Some people have tried a range of different types of drugs. Have you taken drugs before? If so, what drugs have you tried?	Yes 1 No 0 Specify_____	
Q505	Some people have tried injecting drugs using a syringe. Have you injected drugs during the last three months?	Yes 1 No 0	
Q506	In the past three months, have you sniffed (snorted), swallowed, or smoked any drug or something to make you feel high?	Yes 1 No 0	→ **Q509**

No.	QUESTIONS, INSTRUCTIONS & FILTERS	RESPONSES	GO TO
Q507	What did you take? (**MULTIPLE RESPONSES POSSIBLE)**	Marijuana 0 1 Crack 0 1 Heroin 0 1 Amphetamines (speed, slimming tablets, Miror) 0 1 Other Specify_____	
Q508	How old were you when you first sniffed (snorted), swallowed, or smoked any drug or something you feel high?	_____ years	
Q509	During the past three months, how often have you been using drugs? **READ OUT**	All the time 1 Most of the time 2 Half of the time 3 Sometimes 4 Never in the past 3 months 5	
Q510	Have you ever used needles to give yourself an injection or to "shoot up"?	Yes 1 No 0	→ **Q514**
Q511	In the past three months have you used needles to give yourself an injection or to "shoot up"?	Yes 1 No 0	
Q512	What drugs did you inject? (MULTIPLE RESPONSES POSSIBLE)	Cocaine alone 0 1 Heroin alone 0 1 Heroin and Cocaine together 0 1 Amphetamines alone 0 1 Other Specify	
Q513	How old were you when you first injected any drug?	Age_____	
Q514	Have you ever smoked?	Yes 1 No 0	→ **Q601**
Q515	How old were you when you started smoking?	Age_____	
Q516	How often have you smoked during the last three months? **READ OUT**	Every day 1 Most of the time 2 Half of the time 3 Sometimes 4 Never in the past 3 months 5	
Q517	On the average, about how many cigarettes a day (do you now smoke/did you smoke)?	Number_____	
Q518	Have you ever made a serious attempt to stop smoking cigarettes?	Yes 1 No 0	
Q519	Do you smoke cigarettes now?	Yes 1 No 0	
	AIDS		
Q601	How were you infected with HIV? (MULTIPLE RESPONSES POSSIBLE)	Sex 0 1 Drug use 0 1 Blood transfusion 0 1 Accident 0 1 Other Specify _____	
Q602	How long you have been living with HIV?	Months _____	

No.	QUESTIONS, INSTRUCTIONS & FILTERS	RESPONSES	GO TO
	Sometimes people with HIV have symptoms, Thinking about the last three months, how often did you have each of the following symptoms?		
Q603	Fatigue or loss of energy that keeps you from doing the things you need or want to **READ OUT**	Never 1 Rarely 2 Sometimes 3 Often 4	
Q604	Fever or high temperature **READ OUT**	Never 1 Rarely 2 Sometimes 3 Often 4	
Q605	Loss of balance in walking or getting up from a chair or bed **READ OUT**	Never 1 Rarely 2 Sometimes 3 Often 4	
Q606	Skin problems, such as a rash, sores or dryness **READ OUT**	Never 1 Rarely 2 Sometimes 3 Often 4	
Q607	Cough of any type of severity **READ OUT**	Never 1 Rarely 2 Sometimes 3 Often 4	
Q608	Headache of any type of severity **READ OUT**	Never 1 Rarely 2 Sometimes 3 Often 4	
Q610	Have you had significant weight lost during the last three months (unrelated to giving birth)?	Yes 1 No 0	
Q611	Have you been hospitalized during the last three months?	Yes 1 No 0	
Q612	How long you have been taking HIV medications?	Specify months_____	
Q613	Has anyone who lived in your household died in the last 12 months?	Yes 1 No 0	→ **Q615**
Q614	How many people in total in your household (including children and other relatives) died during the last 12 months?	Number_____	
Q615	During the last three months, how many days were you unable to work due to illness?	Number of days_____	If No, skip to → **Q617**
Q616	During the last three months, how many days were you sick and bedridden?	Number of days_____	
Q617	Have you had a genital **discharge** during the past three months?	Yes 1 No 0	
Q618	Have you had a genital **ulcer**/sore during the past three months?	Yes 1 No 0	
Q619	Have you ever received treatment from a traditional healer for HIV?	Yes 1 No 0	

No.	QUESTIONS, INSTRUCTIONS & FILTERS	RESPONSES		GO TO
Q620	Is anyone else in your home HIV positive?	Yes No Do not know	1 0 9	
Q621	Are they currently on Anti-retroviral Therapy?	Yes No	1 0	
Q622	Is anyone in your household ***currently*** taking ARVs to prevent mother to child transmission during pregnancy?	Yes No	1 0	
Q624	Do you think HIV/AIDS is a punishment from God for promiscuous people?	Yes No	1 0	
Q625	Do you think AIDS is just one way of dying - it cannot be avoided?	Yes No	1 0	
Q626	In general, would you say your health is? **READ OUT**	Excellent Very good Good Fair Poor	1 2 3 4 5	
Q628	Do you feel tired? **READ OUT**	All of the time Most of the time Some of the time A little of the time None of the time	1 2 3 4 5	
Q629	During the last three months, have you been unable to do certain kinds of work, housework, school work because of your health?	No Yes for some of the time Yes, for all of the time	0 1 2	
	SEXUAL BEHAVIOUR			
Q701	Have you had sexual relations in the past three months?	Yes No	1 0	→ **Q703**
Q702	With how many people have you had sex in the past three months?	Number _____		
Q703	Do you currently have a boyfriend/ girlfriend or at least have had one during the last three months?	Yes No	1 0	→ **Q706**
Q704	How many times have you had sex with your boyfriend /girlfriend in the last three months?	Number_____		
Q705	How often do you use condoms with your boyfriend/girl friend? **READ OUT**	Always Most of the time Half of the time Sometimes Never	1 2 3 4 5	
Q706	Have you had sex outside of marriage during the last three months?	Yes No	1 0	→ **Q709**
Q707	With how many people have you had sex outside of marriage in the past three months?	Number_____		

No.	QUESTIONS, INSTRUCTIONS & FILTERS	RESPONSES	GO TO
Q708	How often do you use condoms with sexual partners? **READ OUT**	Always 1 Most of the time 2 Half of the time 3 Sometimes 4 Never 9	
Q709	During the last three months, have you had sex with any casual boyfriend/girlfriend/lovers?	Yes 1 No 0	→ **Q711**
Q710	How often you use condom with these casual partners? **READ OUT**	Always 1 Most of the time 2 Half of the time 3 Sometimes 4 Never 5	
	CONCURRENT PARTNER RELATIONSHIP (Now I am going to ask you about your overlapping sexual partner relationships in the past three months). By this, I mean sexual relationships that you could have had while you were in sexual relationships with your spouse or regular partner or FSWs). This could also referred to as plot 2 in certain situations)		
Q711	Now tell me, how many such concurrent sexual partners did you have in last three months?	Number_____	
Q712	In the past three months, have you adopted new behaviour (or Modified your behaviour) specifically to live positively?	Yes 1 No 0	→ **Q714**
Q713	What behaviour have you adopted in the last three months? (MULTIPLE RESPONSES POSSIBLE)	Use condoms consistently with all partners 0 1 Use condoms with partners I do not trust 0 1 Have abstained from sex 0 1 Have reduced number of sexual partners 0 1 No longer have sex with casual partners/CSWs 0 1 Other (Specify)_____ 0 1	
Q714	What does "safe sex" mean to you? (MULTIPLE RESPONSES POSSIBLE)	Abstain from sex 0 1 Use condom 0 1 Avoid multiple sex partners 0 1 Avoid sex with commercial sex workers 0 1 Have non-penetrative sex 0 1 Get HIV testing before sex 0 1 Do not know 0 1 Other (Specify)_____	
Q715	Do you have safe sex yourself?	Yes 1 No 0	→ **Q717**

No.	QUESTIONS, INSTRUCTIONS & FILTERS	RESPONSES	GO TO
Q716	What do you do in that regard? (MULTIPLE RESPONSES POSSIBLE)	Abstain from sex 0 1 Use condom every time 0 1 Limit number of sex partners 0 1 Only have one partner 0 1 Avoid sex with commercial sex workers 0 1 Having non-penetrative sex 0 1 Get HIV testing before sex 0 1 Do not know 0 1 Other (Specify)_____	
Q717	When people talk about "abstinence" to prevent AIDS, what does "abstinence" mean to you? (MULTIPLE RESPONSES POSSIBLE)	Not having sex 0 1 Not having sex with more than one partner 0 1 Having non-penetrative sex 0 1 Don't know 0 1 Other (Specify)_____	
Q718	Do you abstain from sex at any time?	Yes 1 No 0	→ **Q720**
Q719	For how long you have been abstaining from sex?	Months_____	
Q720	Do you think abstinence (doing without sex) is possible?	Yes 1 No 0	
Q721	Do you think long-term abstinence leads to physical problems and/or infertility?	Yes 1 No 0	

I'm going to read another set of statements. Please tell me if you agree or disagree with what I say.
Note: interviewers to probe as to whether they feel "strongly" or "somewhat" for each response.

		Strongly Agree	Some what Agree	Some what Disagree	Strongly Disagree	
Q801	I worry about what I should do to prevent AIDS.	0	1	2	3	
Q802	My risk for AIDS seems to be increasing.	0	1	2	3	
Q803	The fear of God makes me feel nervous about engaging in sex outside of marriage.	0	1	2	3	
Q804	Religious teaching hasn't really affected my behaviour .	0	1	2	3	
Q805	I am not concerned about sex outside of marriage.	0	1	2	3	
Q806	I will avoid having sex outside of marriage altogether.	0	1	2	3	
Q807	I will have protected sex only with my marital partner.	0	1	2	3	
Q811	Going for prayer meetings is beneficial.	0	1	2	3	

No.	QUESTIONS, INSTRUCTIONS & FILTERS	RESPONSES				GO TO
Q812	Going for prayer meetings improves one's health.	0	1	2	3	
	COPING STRATEGIES					
Q902	I have been using alcohol or other drugs/medication to make myself feel better.	0	1	2	3	
Q903	I have been giving up trying to deal with the situation.	0	1	2	3	
Q904	I have been criticizing myself.	0	1	2	3	
Q905	I have been getting emotional support from other people.	0	1	2	3	
Q906	I have been getting comfort and understanding from someone else.	0	1	2	3	
Q908	I have been using alcohol or other drugs/medications to help me get to know what to do.	0	1	2	3	
Q909	I have been blaming myself for things that happened.	0	1	2	3	
Q910	I have been arguing with other people around me.	0	1	2	3	

THIS IS THE END OF THE QUESTIONNAIRE

THANK THE PERSON FOR HER/HIS COOPERATION AND PARTICIPATION

Appendix 6 - Chinyaja (Local Language) Version (Questionnaire)

ZICITIDWE ZAMUMIPINGO-PANDONDOMEKO YA KADOYO KALIWONDE-WONDE MUDELA YA LUSAKA-ZAMBIA. MWAMENE KUZILESA KUKHULUPILIKA MUCHIKWATI KUTHANDIZA MUNJILA ZONSE ZONKHUZA KADOYO NDI MATENDA YA KALIWONDE-WONDE.

PEPALA YA MAFUNSO

[Mpindi yo yenelezeka ndi-khumi limodzi ndi zisanu kafikila makhumi awiri]

[Ofunsa: Chonde lembani yankho monga ilili mupepala ya cibvomelezo. Kodi munthu anabvomela kutengako mbali mu chimpunzitso?]

INDE [1] –PITILIZANI NDI MAFUNSO

AI [2] – LEKEZANI NDI KUFUNSA

NAMBALA	MAFUNSO.ZIDZIWITSO ZOTULUKAMO	MAYANKHO	PITANI KU
	GAWO LOYAMBA: MBIRI YAMUKHALIDWE		
Mafunso 101	Chilengedwe cha oyankha. [lembani osafunsa]	Mamuna: 1 Mukazi: 2	
102	muna badwa mu mwezi ndi chaka chiti? [funsani chitupa ngati ndi odonda]	Mwezi…… Chaka……	
103	Munakwanitsa zaka zingati pa chisangalalo chanu chothela kubadwa. [linganizani funso yo yamba ndi ya chiwiri, konzani ngati zasiyana]	Zaka zathunthu	

105	Munakhalalako zaka zingati ku sukulu, kuphatikiza, primary, secondary, college.	Zaka zosiliza	
107	Mukhala ndi yani	Ndekha, 1 Ndi banja, 2 Ndi a abwana, 3 Azanga [akunchito] Bena [kambani] 4	
109	Kodi inu kapena Banja lanu muli ndi [werengani ndondomeko, ikani kozungulila ngati, katungu alibe] Mayankho ambiri oyenela] Ngati katundu sugwila, nchito, funsani ngati uno gwilapo nchito miyezi yitatu kumbuyo.	Njinga 0 1 Muthuthuthu 0 1 Chimbayambaya 0 1 Videwo 0 1 Chilimba 0 1 Wilesi yaka nema 0 1 Filigi 0 1 Pulazi 0 1 Nyumba 0 1 Foni 0 1	
110	Kodi amu banja lanu alinazo zinthu izi? Werengani ndondomeko ngati sugwila nchito, funsani ngati una gwilapo nchito miyezi yitatu kumbuyo	Lamya Magesi Manzi yaku mpompi Chimbudzi cho gujumula	

111	Mu gwila nchito yanji?	Nkhanizaumoyo/ kugwilanchito/kupitaku sukulu 1 kudwalakusakwanilitsa kugwilanchito/ndikupitaku sukulu 2 Kudwalakwambiri 3 yofanikaanasi 4 Zina……. ……..	
112	Kodi mukwanitsa kusebenza?	Inde 1 Ndimalobva 2 Sinditsebenza 3 Ndikali kufuna-funa nchito 4 Zina……	
113	Munalandila zingati pamodzi pakutha kwa chaka?	zingati-	
114	Miyezi itatu yapitayo mwagwilitsa nchito ndalama pa izi: werengani mokuwa	Kumwakubawa/yumba yamowa. 0 1 Kubvina ku nyumba ya mowa 0 1 Fodya 0 1 Zina…….	

	GAWOLACIWIRI: UKWATI NDI KUBALA ANA		
201	Kodi ndinu okwatila	Mbeta 0 1 Okwatiwa/owatila 0 2 Olekedwa 0 3 Osiyana 0 4 Ofedwa 0 5	
202	Muli ndi ana/munabala ana	Inde 1 Iyai 0	
203	Munabala ana amuna ndi akazi angati/ali ndi moyo	-nambala ya ana amuna ali moyo …… -nambala ya ana akazi ali moyo……..	
	KUSAMALILA UMOYO		
301	Miyizi khumi ndi iwili yapita iyi inu kapena amembala amu nyumba ino anakanizidwa thandizo la umoyo cifukwa cholepela kulipila	Inde 1 Ai 0 Sindiziwa 8	
302	Pa miyezi khumi ndi iwiri yapita, inu ndi a membala wa nyumba ino ana pasidwapo ka pepala kogulilapo mankhwala ndipo analephela cifukwa	I nde 1 Iyai 0	

	chopanda ndalama	Sindiziwa 8	
303	Kodi aliko a membela a nyumba ino anapita kukhala kwina cifukwa chakuti inu muna lephela kuba pasa zofunikila pa miyezi khumi ndi ziwili yapitayo	Inde 1 Ai 0 Sindiziwa 8	
304	ngati inde ni angati	Nambala	
305	Alipo anthu amene mulinawo mu nyumba muno ochokela kuma nyumba ena cifukwa chosakwanilitsa kuba sunga pa miyezi khumi ndi yiwili yapitayo	Inde 1 Ai 0 Sindiziwa 8	
306	Ni ana amasiye angati ochepekela zaka khumi zisanu ndi cimodzi okhala mu nyumba ino?	Nambala…….	
308	Muganiza kuti cikhalidwe cha mu nyumba mwanu kwapita pa mwamba, kapena ai, kapena kunabwela pansi mu miyezi yisanu ndi ziwiri yapitayo?	Yapita pa mwamba Chakhala cimodzi-modzi Chabwela pansi Sindiziba	
	KUGWAPOKWA MAGULUOKHULUPILIKA		
404	Mupemphela mpingo uti?	African methodist. 1 UCZ 2 7th day Adventist 3 RCZ 4 Baptist 5 New Apostolic 6 CMML 7	

		Salvation Army 8 Jehovah's Witness 9 Pentecostal 10 Presbyterian 11 Anglican 12 Catholic 13 Muslim 14 Hindu 15 Zina- kambani 99	
404	Muna badwapo mwa tsopano?	Inde 1 Ai 0	
405	Kodi munabadizika?	Inde 1 Ai 0	
406	Pa miyezi itatu yapitayo munapezekako ka ngati ku mpingo?	Nikalibe 1 Kamodzi chabe 2 Kawiri 3 Kopitila kawiri 4	
407	Pa miyezi itatu yapitayo, mwa pezekako Ku misonkhano yaci Yanjano kangati?	Palibe 1 Ka modzi chabe 2 Kawiri, 3 Ku pitilila kawiri 4	
408	Pa miyezi itatu yopitayo mwapezekako ku misonkhano wothandizika?	Inde 1 Ai 0	
409	Pa miyezi itatu yapitayo mwapezekako kangati ku misonkhano yothandizika	Nambala……	
410	Pa miyezi itatu yapitayo, munapezekaku kumusonkhano yocilisa anthu ku mpingo?	Inde 1 Ai 0	
411	Pa miyezi itatu yapitayo, mwapezekako	Nambala.....	

	kangati ku misonkhano ya cikhulupililo?		
412	Pa miyezi itatu yapitayo mwapezekako ku misonkhano yacikhulupililo?	Inde 1 Ai 2	
413	Pa miyezi itatu yapitayo mwapezekako kangati ku misonkhano yacikulupililo moyankhulisana	Nambala.....	
414	Kodi abusa anu abvomelezana nazo zakusamalila anthu odwala kadoyo ka HIV	Inde 1 Ai 2	
415	Muma sabata anayi yapitayo mwapemphela ka ngati ku mulengi wanu? [WERENGANI MAYANKO MOKUWA]	Tsiku ndi tsiku 1 Kamodzi mu sabata 2 Osa chepekela pa sabata 3 Sinina yeseko 4	
416	Muma sabata inayi yapitayo mwa werenga kangati ku mulengi wanu [WERENGANI MAYANKHO MOKUWA]	Tsiku ndi tsiku 1 Kamodzi mu sabata 2 Osa chepekela pa sabata 3 Sinina yeseko 4	
417	Munafikako kuciyanjano chaku uzimu pa miyezi itatu yapitayo?	Inde 1 Ai 2	
418	Munatengako mbali ku misonkhano yama cilisidwe pa miyezi itatu yapitayo?	Inde 1 Ai 2	
419	Munankalapo mu cipatala cifukwa cha maganizo?	Inde 1 Ai 2	
420	Kodi mukumwako mankhwala cifukwa cha bvuto ya maganizo?	Inde 1 Ai 2	
	CHIGAWO CHA KASEBENZSEDWE KOIPA KA MANKHWALA		
501	Kodi muna mwapo mowa?	Inde 1 Ai 0	**→Q504**
502	Muna mwapo mowa otani pa miyezi itatu kumbuyoku?	Mowa 0 1 Vinyo 0 1 Wisiki/brande 0 1 Kopanda mowa 0 1 Vinangu 0 1 Zina……	
503	Pa miyezi itatu yapitayo, muna mwapo zukumwa monga mowa? Kodi munganene kuti..... **[WERENGANI MOKUWA, ZUNGULUSANI YANKHO IMODZI]**	Tsiku ndi Tsiku 1 Kapena kamodzi pasabata 2 Kosachepekela kamodzi pa sabata olo kulekelathu 3 Sindiziwa 4 Kuliye yankho 9	
504	Anthu ena ayetsako mankhwala osiyana-	Inde 1	

	siyana, inunso munacitapo telo kumbuyoku? Ngati munacitapo, ndi mankhwala otani?	Ai 0 Lankhulani ……..	
505	Anthu ena ayetsako kudzilatsa mankhwala ndi jekeseni. Kodi inu munacitapo zotele pa miyezi itatu kumbuyoku	Inde 1 Ai 0	→**Q514**
506	Pa miyezi itatu ku mbuyoku muna melapo, kubemapo, kukokapo fodya, mankhwala kapena zinthu zina zoledzeletsa?	Inde 1 Ai 0	→**Q508**
507	Kodi mumakoka ciani?	Mbanje 0 1 Crack 0 1 Heroin 0 1 Amphetamines[mankhwala olengetsa kuthamanga kwa mbiri, kuchepetsa thupi, mirror] 0 1 Zina kambani 0 1	
508	Munali ndi zaka zingati pomwe munayamba kununsha, kumela, kukoka kubema fodya/mankhwala yoledzeletsa?	Zaka.....	
509	Pa miyezi itatu yapitayo, ndi kangati munali kusebenzetsa mankhwala yoledzeletsa?	Nthawi zonse 1 Nthawi zambiri 2 Nthawi yochepekela 3 Nthawi zina 4 Nikalibe kusebenzetsapo 5	
510	Kodi munasebenzetsapo nyeleti kuti mudzilatse kufuna kuledzela?	Inde 1 Ai 0	→**Q514**
511	Pa miyezi itatu yapitayo munasebenzetsapo nyeleti kuti mudzilatse jekeseni mofuna kuledzela?	Inde 1 Ai 0	
512	Munasebenzetsa mankhwala otani?	Cocaine 0 1 Heroin 0 1 Heroin ndi cocaine kusankhaniza 0 1 Amphetamines 0 1 Zina……..	
513	Munali ndi zaka zingati pomwe munayamba kumwa mankhwala yoledzeletsa?	Zaka.....	
514	Kodi muna kokapo?	Inde 1 Ai 0	→**Q601**
515	Munuli ndi zaka zingati pamene munayamba kukoka?	Zaka.....	

516	Mwakoka kangati pa miyezi itatu yapitayo **[WERENGANI MO KUWA]**	Tsiku ndi tsiku 1 Kambiri 2 Nthawi yo chepekela 3 Nthawi zina 4 Sinina kokepo kwa miyezi itatu kumbuyoku 5	
517	Modzibika. Mumakoka ndudu zingati pa tsiku, kodi mukali kukoka kapena muna kokapo?	Inde 1 Ai 0	
518	Kodi munayetsapo kuleka kukoka fodya modzibika?	Inde 1 Ai 0	
519	Kodi mumakoka fodya pali ino nthawi	Inde 1 Ai 0	
	KALIWONDE-WONDE (HIV)		
601	Kodi munayambula motani kadoyo ka HIV?	Mosebenzetsa mankhwala 0 1 Paku patsidwa magazi 0 1 Pa ngozi yapa museu 0 1	
602	Kodi mwakhala nthawi yotani ndi kadoyo ka HIV?	Miyezi.....	
	Nthawi zina anthu odwala kadoyo ka HIV amakhala ndi zionetselo. Pa miyezi itatu yapitayo, ndi kangati zotele zima onekela?		
603	Kutopa kapena kusowa mphamvu kuti mugwile nchito yomwe mufuna	Sizinacitikepo 1 Mwapa tali-patali 2 Nthawi zina 3 Kambiri 4	
604	Kumva mphepo/kutentha thupi	Sizinacitikepo 1 Mwapa tali-patali 2 Nthawi zina 3 Kambiri 4	
605	Kulephela kuyenda/kunyamuka pamu mpando/bedi	Sizinacitikepo 1 Mwapa tali-patali 2 Nthawi zina 3 Kambiri 4	
606	Bvuto ya nkanda yathupi, ziseseya, tulonda kapena kuyuma nkanda yatupi	Sizinacitikepo 1 Mwapa tali-patali 2 Nthawi zina 3 Kambiri 4	
607	Kukhosomola ndi cifuwa kwa nthawi yayitali.	Sizinacitikepo 1 Mwapa tali-patali 2 Nthawi zina 3 Kambiri 4	

608	Kuwawa kwa mutu kwa nthawi yayitali	Sizinacitikepo 1 Mwapa tali-patali 2 Nthawi zina 3 Kambiri 4	
610	Kodi munachepekelako makilo pasikelo pa miyezi itatu yapitayo? [osati kwa obala]	Inde 1 Ai 0	
611	Kodi bana kusunganipo mucipatala pa miyezi itatu yapitayo?	Inde 1 Ai 0	
612	Ndi miyezi ingati yomwe inu mulikumwa mankhwala ya kadoyo ka HIV?	Masulani.....	
613	Kuli amene anatisiya omwe munali kukhala nao pa miyezi khumi ndi ziwiri zapitazi?	Inde 1 Ai 0	**→Q615**
614	Ndi angati anthu mu banja lanu [kuyikapo ana ndi abale anu omwe anatisiya mu miyezi khumi ndi ziwiri kumbuyoku?	Nambala.....	
615	Pa miyezi itatu yapitayo, ndi kangati pomwe inu munalephela kugwila nchito cifukwa cha matenda?	Nambala yama tsiku.....	
616	Pa miyezi itatu kumbuyoku, ndi matsiku angati omwe inu muna dwala ndiponso kukhala cigonele mu bedi?	Nambala yama tsiku.....	
617	Kuli zomwe zinali kutuluka kuziwalo?	Inde 1 Ai 0	
618	Pa miyezi itatu yapitayo, munali ndi cilonda kuciwalo?	Inde 1 Ai 0	
619	Muna landilako thandizo monga mankhwala acimunthu kwa sing'anga?	Inde 1 Ai 0	
620	Kuliko munthu wina munyumba yanu odwala kadoyo ka HIV?	Inde 1 Ai 0 Sindiziwa 9	
621	Kodi pali ino nthawi ali kumwa mankhwala ya ARVs	Inde 1 Ai 0	
622	Kodi aliko ena munyumba yanu ali kumwa mankhwala ya ARVs kuletsa kuyambukitsa matenda omwe awa ku ana ngati ali ndi pakati?	Inde 1 Ai 0	**→Q624**
624	Kodi muma ganizo yanu kadoyo ka HIV/matenda ya kaliwonde-wonde ndi cilango kuchokela kuli mulengi ku anthu osamvela?	Inde 1 Ai 0	
625	Mukuganiza kwanu kaliwonde-wonde ndi matenda monga aya ena?	Inde 1 Ai 0	
626	Inu, umoyo wanu munganene kuti uli.....	Bwino kwambiri 1 Chabe bwino 2	

		Bwino 3 Bwino pa ng'ono 4 Si uli bwino 5	
628	Kodi muma mvela kutopa **[WERENGANI MOKUWA]**	Nthawi zonse 1 Kambiri 2 Nthawi zina 3 Pang'ono 4 Kulibe 5	

629	Pa miyezi itatu yapitayo, muna lephelapo ku gwila nchito zina, zamu nyumba, cifukwa cha umoyo wanu?	Iyayi 0 Inde, nthawi zina 1 Inde, thawi zones 2	
	MUKHALIDWE WA ZA CHIENGEDWE		
701	Kodi muna khalapo malo amodzi ndi mkazi/mwamuna pa miyezi itatu yapitayo	Inde 1 Ai 0	**→Q703**
702	Ndi anthu angati mwakhala nawo malo amodzi pa miyezi itatu yapitayo?	Nambala……..	
703	Kodi muli ndi bwezi laci muna/wamukazi kapena munaliko ndi umodzi pa miyezi itatu yapitayo?	Inde 1 Ai 0	**→Q706**
704	Mwakhala malo amodzi kangati ndi cisumbali wanu pa miyezi itatu yapitayo?	Nambala……..	
705	Musembenzetsa kangati mphila pomwe mukhala malo amodzi ndi abwenzi lanu [boy friend/girl friend]	Nthawi zonese 1 Nthawi zambiri 2 Kochepekela 3 Nthawi zina 4	

		Sitinasebenzetsepo 5	
706	Kodi munakhalapo malo amodzi ndi amuna/ akazi omwe si amunyumba?	Inde 1 Ai 0	→**Q709**
707	Ndi angati omwe muna khala nawo malo amodzi amene si amu nyumba mwanu?	Modzi 1 Modzi kufikila asanu 2 Asanu kapena khumi 3 Kupitilila khumi 4	
708	Musebenzetsa kangati ma kondomu pomwe mu khala malo amodzi?	Nthawi zonese 1 Kambiri-mbiri 2 Kochepekela 3 Nthawi zina 4 Sinisebenzetsa 5	
709	Pa miyezi itatu yapitayo, munakhala malo amodzi ndi munthu ozaziba bwino?	Inde 1 Ai 0	→**Q711**
710	Ndi kangati pomwe inu musebenzetsa mphila ndi anthu osaziba bwino pokhala malo amodzi ndi iwo.	Nthawi zones 1 Kambiri-mbiri 2 Kochepekela 3 Nthawi zina 4 Sinisebenzetsa 5	
	CIBWELAZELA CHACI YANJANO NDI CISUMBALI [TSOPANO NDIZA KUFUNSANI ZACHIBWELEZELA CHACIYANJANO NDI CITSUMBALI CHANU PA MIYEZI ITATU YAPITAYO] MWAICI NDIZATHANDAUZILA		

	KUKHALA MALO AMODZI PAMENE MUNALI MUCIYANJANO NDI ALIYENSE ANGAKHALE MKAZI/MWAMUNA WAKUNYUMBA, WAMUMUSEU ETC. **MWACINDITANDAUZILA** **YANJANO NDI ALIYE**		
711	Tsopano ndiuzeni kodi mwankhala ndi ashamwali angati mu miyezi itatu yapitayo?	Modzi 1 Kuchokela umodzi - Kufikila asanu 2 Kuchokela asanu- Kufikila nkhumi 3 Kupitila khumi 4	
712	Pamiyezi itatu yapitayo mwatengako cikhalidwe cha nyowani?	Inde 1 Ai 0	**→Q714**

713	Ndi cikhalidwe chotani cimene mwatengela mu miyezi yitatu yapitayo. **[Ndikotheka kukhala mayankho yosiyana-siyana]**	Kusebenzesa mpila Kosalekeza ndi aliyense 0 1 Ndinasebenzesa mpila ndianthu amene sindikulupilila 0 1 Kusiyilathu kukhala malo amodzi ndi aliyense 0 1 Ndachefyako nambala	

		ya zisumbali 0 1 Sindikhala malo amodzi ndi zisumbali amunjla 0 1 Zina [longosolani]…….	
714	Kodi kukhala malo amodzi ndi cisumbali kosamalila cithandauza ciani kwainu? **[Ndikothekha kukhalandi mayankho yosiyana-siyana]**	Kulekelathu kukhala malo amodzi ndi aliyense 0 1 Kusebenzetsa mpila 0 1 Kupewa zisumbali zambiri 0 1 Kupewa kukhala malo amodzi ndi anthu aciwele wele 0 1 Kupimisazakalombo musanakhale malo Amodzi 0 1 Sindiziwa 0 1 Zina [Longosolani]……..	
715	Kodi muma zicinjira po nkhala malo amodzi ndi munthu	Inde 0 1 Ai 0 1	**→Q717**
716	Mucita ciani pa zotele **[Ndikotheka kukhalandi mayakho yosiyana-siyana]**	Kuleka kukhala malo amodzi 0 1 Kusebezesta mpila	

		nthawi zonse 0 1 Kucheptsa zistumbali 0 1 Kukhala malo amodzi 0 1 Kukhala ndi cisumbali cimodzi 0 1 Kupewa anthu aciwele-wele 0 1 Kupimitsa za kalombo ka HIV 0 1 Sindiziwa 0 1 Zina: Longosolani] …….	
717	Ngati anthu alankhula zakuletsa, kucinjiliza matende, yakalowonde-wonde, kodi kudziletsa kuthandauzanji kwa inu **[Ndikotheka kukhalandi mayankho ambiri]**	Kusankhala malo amodzi ndi aliyense 0 1 Kusakhala malo amodzi ndi anthu amodzi ndi anthu ambiri 0 1 Sindidiziwa 0 1 Zina: [Longosolani]	
718	Kodi muma ziletsa pa nthawi yina?	Inde 0 1 Ai 0 1	**→Q720**
719	Kodi mwakhala mukudziletsa	Miyezi…….	

	kangati?		
720	Kodi muganiza kuti kudziletsa **[kusankhala malo amodzi nikotheka?]**	Inde 0 1 Ai 0 1	
721	Kodi muganiza kuziletsa kwa nthawi kungalete bvuto pa thupi lanu ndi/ kapena kusabeleka?	Inde 0 1 Ai 0 1	

MAFUNTSO, ZOKHONKHA	**MAYANKHO**		
Ndiza werenga ndondomeko yina yamau. Chonde mundi uze ngati mubvomela kapena kukana ndi zomwe ndi za nena. Note: ofunsa alowepo ngati ndiodzipeleka payankho ili yonse.			
Abvomera mwa mphamvu	Abvomela Mo kaiko	Akana Mo kaika	akanilatu
801 Ndisakamala ndi comwe ndizachita Kuchinjiliza matenda ya kaliwonde wonde wonde 0	1	2	3
802 Ciopsyedzo kwa ine pa matenda ya Kaliwonde-wonde cipita pasogolo 0	1	2	3
803 Kuyopa Mulengi kuma panga ine kukhala ndi matha malo amodzi ndi munthu ndi Kalibe kulowa mu cikwati 0	1	2	3

804 Siphunzisto cha uzimu sicina khuzechi khalidwe change	0	1	2	3
805 Sindili okhuzidwa za khukhala malo amodzi pamene sindili mu banja	0	1	2	3
806 ndiza pewa kukhala malo amodzi pamene Sindili mubanja	0	1	2	3
807 Ndiza zicinjiliza ndi mkazi/mwamuna wanga Chabe	0	1	2	3
809 Kupita kuma pemphelo cima thandiza	0	1	2	3
812 kupita kuma thandizo zaumoyowamunthu	0	1	2	3

NJIRA ZOTHANDIZILA

902 nda khala ndili kusebezesta zolezelets ndimvele bwino	0	1	2	3
903 nda khala ndili yetsa kusebenzelapo pa zimenezi	0	1	2	3
904 Nda khala ndili kuzitsusta	0	1	2	3
905 Nda khala ndili kuthandizika mumaganizo ndi anthu ena	0	1	2	3
906 Nda khala ndili kupeza cithondozo kuchokela kwa munthu wina	0	1	2	3
907 Nda khala ndili kusebenzetsa ndi mankhwala ena kuti ndi thandizik Kuziwa chocita	0	1	2	3
908 Nda khala ndili kuzi tsutsa pa zinthu zomwe zina citika	0	1	2	3

909 Uda khala ndili kutsutsana ndi anthu ozungulila pafupi ndi ine	0	1	2 3
910 Uku ndiye kutha kwa pepala ya mafunso Yamikilani munthu pa cigwilizano ndi Kutengako mbali	0	1	2 3

Appendix 7 - Impact Of Congregation Based HIV/AIDS Programmes In Lusaka, Zambia: How Abstinence And Marital Fidelity Efforts Function In Overall Strategies Addressing HIV/AIDS (Focus Group Discussion Guidelines)

FOCUS GROUP DISCUSSION GUIDELINES

Good day, I am _____(name). I am from the Circle of Hope (COH) Family Care Centre. a congregation based HIV/AIDS support group initiative undertaken by the Northmead Assemblies of God Church in Lusaka, Zambia.We are carrying out a study to evaluate HIV/AIDS programmes in churches. We are looking into creating awareness about the transmission of the AIDS virus and the methods of risk reduction through preventive measures such as abstinence and marital faithfulness

You have been selected to participate in this study randomly. The information gathered here will remain confidential. I will not take your name, and you do not have to answer any questions that you do not want to. Your participation in the study is voluntary and you will not be affected in any way if you decide not to participate.

General introduction for all FGD groups

Each FGD should start with an introduction by the moderator explaining what will happen during the discussion and general rules of participation. The introduction should cover the following issues:
Why the participants have been brought together
Why what they are doing is important
Confidentiality (first names only)
What you will do with the results
Who will hear the tapes
Importance of one speaker at a time
Encouragement of differing views
Necessity of positive and negative responses
Neutrality of moderator
Duration of focus group and when incentives will be received

This introduction will also be the time in which participants will introduce themselves and start making dialogue. After the introduction the moderator should initiate the discussion with general, pre-prepared questions and pre-prepared probe questions to encourage participants to provide more information (ex. Can you explain your statement? OR How would you feel…?)

Health Care
What is your functional status?
Some people have tried a range of different types of medications.
Probe: What are the types of medication you have taken before?
How long you have been living with HIV?
Probe: How long you have been taking HIV medications?
Sometimes people with HIV have symptoms, Thinking about the last three months, what are the different symptoms have you had?

Impact of Congregation /Faithbased Programmes

What is your religious denomination?
How long you have attending the religious denomination?
What is experience of attending prayer meetings?
Probe: What is the impact?
What is your experience of attending congregation faith based workshops?
Probe: Its impact on spiritual, mental and physical health.
What is the impact of faith based intervention?
What are your general views about congregation/faith based programmes?
Probe: Intention to continue to attend the congregation/faith based intervention?
What is your experience of attending congregation/faith based programmes?
Probe: In what way congregation/faith based programems are effective in your life?

Sexual Behaviour:
A lot of people here are married, right? Tell me about married relationships—is it always one man-one woman, or are there sometimes more than one partner each?
Do people who are married have sexual relationships with people they aren't married to? Tell me about these relationships.
What about sexual relationships involving people who aren't married, does that ever happen?
Do people who are not married have sexual relationships with more than one person at a time? Tell me about these relationships.
Should people adopt behavioral practices to protect themselves and others from sexually transmitted diseases, including HIV?
What behaviour have you adopted in the last three months?

END

Appendix 8 - Impacts Of Congregation-Based HIV/AIDS Programmes In Lusaka (In-Depth Interview Guide)

IMPACT OF LIFE TRANSFORMATION SEMINAR (LTS)

RESEARCH ASSISTANT (RA00):
INFORMANT (INF):

What are your general views about the life transforming seminar? Probe: What did you learn and experience from the programme?

Answer:

What is your spiritual life experience before and after attending the programme?

Answer:

What is your experience in faith life before and after attending the programme?

Answer:

What is your emotional life experience before and after attending the programme?

Answer:

What is your overall experience in physical health before and after attending the programme?

Answer:

What is your moral behavior experience before and after attending the programme?

Answer:

What is your experience in abstaining from sex before and after attending the programme?

Answer:

What is your experience in marital fidelity and faithfulness before and after attending the programme?

Answer:

What is your experience in safe sexual practices before and after attending the programme?

Answer:

In what ways has attending the programme impacted the overall wellbeing of your life?

Answer:

What specific new behavior have you adopted as a result of attending the faith based intervention programme?
Answer:

How do you think we can support you further in your overall spiritual, emotional and physical development?

Answer:

Is there anything else, you would like to tell us?

Appendix 9 - Life Transformation Seminar (LTS) Curriculum - Notes Guide (12-Week Master Module Outline)

GOD AND MAN- (LESSONS I-II)
Focuses on man's opportunity for a new relationship with God through salvation

JUSTIFICATION - (LESSONS III-IV)
Focuses on the Christian doctrine of Justification

FACTS OF A TRANSFORMED LIFE - (LESSONS V-VI)
Focuses on motifs of modelling a transformed life that aims to transform others by exemplary Christian conduct

OPEN SESSION FOR FEED BACK
Interactive review of material covered in weeks 1-3
Testimonies and experience sharing

FAITH – (LESSSONS VII-VIII)
Focuses on the role of faith in the life of a believer

THE KINGDOM OF GOD – (LESSONS IX-X)
Focuses on the nature life in God's Kingdom here on earth. Also reflects on the future hope of life in heaven

HEALTH, HEALING, WHOLENESS: GOD'S WAY – (LESSONS XI-XII)
Focuses on God's provision for the divine healing and also shows the legitimacy of scientific medicine as part of God's providence for improved lives and alleviating subhuman suffering which result from effects of disease

OPEN SESSION FOR FEED BACK
Interactive review of material covered in weeks 4-7
Testimonies and experience sharing

GOD'S WILL FOR YOUR LIFE – (LESSSONS XIII-XIV)
Focuses on relevance of God's guidance in vocational and livelihood matters including home, family and finances

WALKING IN THE NEWNESS OF LIFE (LESSONS XV-XVI)
Focuses on the Spirit-led life with detailed biblical models of the guidance of the Holy Spirit in a believer
WRAP UP AND REVIEW OF TOPICS (LESSONS XVII-XVIII)
Interactive review of overall material covered
Re-emphases the role of prayer and worship in the life of a believer and the responsibility to witness for Christ
CLOSING FEED BACK SESSION
Testimonies and experience sharing

Appendix 10 - Unaids Preferred Terminology (Exerpts)[1]

Introduction

These guidelines to UNAIDS' preferred terminology have been developed for use by staff members, colleagues in the Programme's 10 Cosponsoring organisations, and other partners working in the global response to HIV.

Language shapes beliefs and may influence behaviours. Considered use of appropriate language has the power to strengthen the global response to the epidemic. UNAIDS is pleased to make these guidelines to preferred terminology freely available. It is a living, evolving document that is reviewed on a regular basis. Comments and suggestions for additions, deletions, or modifications should be sent to terminology@unaids.org.

The adjacent boxed list (summary of preferred terminology) highlights the most important points that we recommend users follow.

Summary of preferred terminology and errors to avoid

Past terminology	Preferred terminology
HIV/AIDS;HIV and AIDS	**Use the term that is most specific and appropriate in the context** to avoid confusion between HIV (a virus) and AIDS (a clinical syndrome). Examples include 'people living with HIV', 'HIV prevalence', 'HIV prevention', 'HIV testing and counselling', 'HIV-related disease', 'AIDS diagnosis', 'children orphaned by AIDS', 'AIDS response', 'national AIDS programme', 'AIDS service organisation'. both 'HIV epidemic' and 'AIDS epidemic' are acceptable, but 'HIV epidemic' is a more inclusive term.
AIDS virus	**t**here is no AIDS virus. **t**he virus that causes AIDS is the human immunodeficiency virus **(HIV)**. Please note that 'virus' in the phrase 'HIV virus' is redundant. Use 'HIV'.
AIDS-infected	No one is infected with AIDS; AIDS is not an infectious agent. AIDS describes a syndrome of opportunistic infections and diseases that can develop as immunosuppression deepens along the continuum of HIV infection from acute infection to death. Avoid 'HIV-infected' in favour of **person living with HIV** or **HIV-positive person** (if serostatus is known).
AIDS test	**t**here is no test for AIDS. Use **HIV test** or **HIV antibody test**. For early infant diagnosis, HIV antigen tests are used.
AIDS victim	Use **person living with HIV**. **t**he word 'victim' is disempowering. Use AIDS only when referring to a person with a clinical diagnosis of AIDS.
AIDS patient	Use the term 'patient' only when referring to a clinical setting. Use **patient with HIV-related illness (or disease)** as this covers the full spectrum of HIV-associated clinical conditions.
Risk of AIDS	Use **'risk of HIV infection' or 'risk of exposure to HIV'** (unless referring to behaviours or conditions that increase the risk of disease progression in an HIV-positive person).

[1] Full document available on www.unaids.org

High(er) riskgroups; vulnerablegroups	Use **key populations at higher risk** (both key to the epidemic's dynamics and key to the response). Key populations are distinct from vulnerable populations, which are subject to societal pressures or social circumstances that may make them more vulnerable to exposure to infections, including HIV.
Commercial sex work	**t**his says the same thing twice in different words. Preferred terms are **sex work, commercial sex,** or the **sale of sexual services**.
Prostitute or prostitution	**t**hese words should not be used. For adults, use terms such as **sex work, sex worker, commercial sex, transactional sex,** or the **sale of sexual services**. When children are involved, refer to **commercial sexual exploitation of children**.
Intravenous drug user	Drugs are injected subcutaneously, intramuscularly, or intravenously. Use **person who injects drugs** to place emphasis on the person first. A broader term that may apply in some situations is **person who uses drugs**.
Sharing (needles, syringes)	Avoid 'sharing' in favour of **use of non-sterile** injecting equipment if referring to risk of HIV exposure or **use of contaminated** injecting equipment if the equipment is known to contain HIV or if HIV transmission occurred through its use.
Fight against AIDS	Use **response to AIDS** or AIDS response.
Evidence-based	Use **evidence-informed** in recognition of other inputs to decision-making.
HIV prevalence rate	Use **HIV prevalence**. **t**he word 'rate' implies the passage of time and should not be used in reference to prevalence. It can be used when referring to incidence over time e.g. incidence rate of 6 per 100 person-years.

Incidence

HIV incidence (sometimes referred to as cumulative incidence) is the number of new cases arising in a given period in a specified population. UNAIDS normally refers to the number of adultsaged 15-49 years or children (aged 0–14 years) who have become infected during the past year.

In contrast, HIV prevalence refers to the number of infections at a particular point in time, no matter when infection occurred, and is expressed as a percentage of the population (like a camera snapshot). In specific observational studies and prevention trials, the term 'incidence rate' is used to describe incidence per hundred person years of observation.

Investment framework

The UNAIDS strategic investment framework was published in 2011 to support better management of national and international HIV responses over the period from 2011 to 2020. Spending on HIV prevention and treatment is an investment that prevents additional costs in future. Major efficiency gains are achieved through community mobilisation, synergies between programme elements, and benefits from the extension of antiretroviral therapy for prevention of HIV transmission. It proposes three categories of investment consisting of six basic programmatic activities, actions to create an enabling environment, and programmatic efforts in other health and development sectors related to HIV. The yearly cost of achievement of universal access to HIV prevention, treatment, care, and support by 2015 is estimated at US$22 billion annually. The additional investment proposed would be largely offset from savings in treatment costs alone.

Key populations at higher risk of HIV exposure

The term 'key populations' or 'key populations at higher risk of HIV exposure'

refers to those most likely to be exposed to HIV or to transmit it – their engagement is critical to a successful HIV response i.e. they are key to the epidemic and key to the response. In all countries, key popula- tions include people living with HIV. In most settings, men who have sex with men, transgender persons, people who inject drugs, sex workers and their clients, and seronegative partners in serodiscordant couples are at higher risk of HIV exposure to HIV than other people. There is a strong link between various kinds of mobility and heightened risk of HIV exposure, depending on the reason for mobility and the extent to which people are outside their social context and norms. Each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context. Don't use the term 'high-risk group' (see group).

'**Know your epidemic, know your response'**

The term 'know your epidemic, know your response' refers to the combination of modes of transmission exercises, resource tracking, and programmatic gap analysis to inform tailored programme planning.

Appendix 11 - Creswell's Ethical Guidelines

Table 3.2 Ethical Issues in Qualitative Research

Where in the Process of Research the Ethical Issue Occurs	*Type of Ethical Issue*	*How to Address the Issue*
Prior to conducting the study	1. Seek college/university approval on campus 2. Examine professional association standards 3. Gain local permission from site and participants 4. Select a site without a vested interest in outcome of study 5. Negotiate authorship for publication	• Submit for institutional review board approval • Consult types of ethical standards that are needed in professional areas • Identify and go through local approvals; find
Beginning to conduct the study	• Disclose purpose of the study • Do not pressure participants into signing consent forms • Respect norms and charters of indigenous societies • Be sensitive to needs of vulnerable populations (e.g., children)	• Contact participants and inform them of general purpose of study • Tell participants that they do not have to sign form
Collecting data	• Respect the site and disrupt as little as possible • Avoid deceiving participants • Respect potential power imbalances and exploitation of participants (e.g., interviewing, observing) • Do not "use" participants by gathering data and leaving site without giving back	• Build trust, convey extent of anticipated disruption in gaining access • Discuss purpose of the study and how data will be used
Analyzing data	• Avoid siding with participants (going native) • Avoid disclosing only positive results • Respect the privacy of participants	• Report multiple perspectives; report contrary findings
Reporting data	• Falsifying authorship, evidence, data, findings, conclusions • Do not plagiarize • Avoid disclosing information that would harm participants • Communicate in clear, straightforward, appropriate language	• Report honestly • See APA (2010) guidelines for permissions needed to reprint or adapt work of others • Use composite stories

Publishing study	• Share data with others • Do not duplicate or piecemeal publications • Complete proof of compliance with ethical issues and lack of conflict of interest, if requested	• Provide copies of report to participants and stakeholders; share practical results; consider website distribution; consider publishing in different languages

Sources: Adapted from APA, 2010; Creswell, 2012; Lincoln, 2009; Mertens & Ginsberg, 2009.